C+D

21 October

Chemist+Druggist
Weekly
www.dotpharmacy.com

Have you heard? Now there's a more comfortable way to go to the loo

Pass it on

Turn the page to find out what a

Now there's a more comfortable way to go to the loo. Pass it on!

There's a major new consumer campaign out there, running across TV, press, PR activity and even taxis and buses. It's about going to the loo and DulcoEase, the first dedicated stool softener readily available for treating and preventing a painful common problem – passing hard stools.

More common than you might think

Over 6 million people in the UK suffer; with as many as 3 million experiencing the problem at least once a week.[1]

New DulcoEase, for a softer and more comfortable way to go to the loo

DulcoEase contains docusate sodium, which softens and hydrates hard stools, usually after a couple of days. It works by decreasing the surface tension of the stool, making it softer by allowing water and salts to penetrate more easily. The softer, more lubricated and slightly increased stool bulk makes it easier to pass and reduces straining. So DulcoEase doesn't make you go but helps to make it more comfortable when you do go.

Recommend DulcoEase

DulcoEase is easy to take

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For more information

Check out the healthcare professional website at:

www.DulcoEase.co.uk

DulcoEase: product information (docusate sodium)
Active ingredient: docusate sodium 100 mg capsules. **Indication.** Stool softener in the prevention and treatment of chronic constipation; to soften hard, dry stools to ease bowel movement and reduce straining or to prevent hard, dry stools and reduce straining in the presence of haemorrhoids (piles) or anal fissure. **Dose:** Adults, Elderly and Children 12 years and over: One capsule up to 5 times per day (maximum 500 mg). Initially try 3 capsules and adjust according to need. Reduce the dose when you feel more comfortable, usually 1-2 days. Children under 12 years: Not recommended. **Contraindications:** Do not take if you have abdominal pain, nausea, vomiting, intestinal obstruction, hypersensitivity to any constituent, or fructose intolerance. Do not take with a mineral oil laxative. **Precautions:** Consult a doctor if you have persistent stomach ache, or need this medicine every day. Contains sorbitol: do not take if sorbitol or fructose intolerant. Contains colouring E110. Please see doctor before taking if pregnant, thinking of becoming pregnant, or breast feeding. **Side-effects:** Rarely diarrhoea, nausea, abdominal cramps or skin rash. **Distributor:** Boehringer Ingelheim Consumer Healthcare, Ellesfield Avenue, Bracknell, Berkshire, RG12 8YS, UK. **Product Licence Holder:** Schwarz Pharma Ltd, 5 Hercules Way, Leavesden Park, Watford, WD25 7GS, UK. **Presentations and retail price:** 30 capsules £4.99. PL 04438/0032 (GSL). For full product information please see summary of product characteristics. Prepared September 2006.
Reference: 1. TNS Onlinebus. June 2004

21 October 2006

Chemist+Druggist

www.dcdigital.com

C+D

News: Remote supervision a 'nightmare', says Sandra Gidley MP

News: Tighter controlled drugs guidelines announced by Department of Health

Features: All the news, views and pictures from The Pharmacy Show

- Up to 21% of adults with asthma are sensitive to aspirin, according to a recent medical review.[1]
- Asthmatics who are sensitive to aspirin may also be cross-sensitive to other non-steroidal anti-inflammatory drugs (NSAIDs), including ibuprofen.[1]
- That's why paracetamol (the active ingredient in Panadol) is recommended as a more suitable alternative to (NSAIDs) for aspirin-sensitive asthmatics.[1,2,3]

When it comes to asthmatics and pain relief, recommend Panadol.

+ Less than 2% of asthmatics are cross-sensitive to paracetamol and aspirin;[1] should reactions occur they are less severe and of shorter duration.[2, 4, 5]

Panadol
Paracetamol
It's my choice.

References 1. Jenkins C et al. BMJ.com. 2004; 328: 434 2. Jenkins C. Am J Ther, 2000; 7: 55-61. 3. Global Initiative for Asthma. Q&A. http://www.ginasthma.com/QAndA.asp?topicId=6&l1=3&l2=2#Q15. 4. Settipane RA et al. J Allergy Clin Immunol. 1995; 96: 480-485. 5. Szczeklik A. Am J Ther, 2002; 9: 233-243.

Panadol Tablets Product Information. Presentation: Each tablet contains Paracetamol 500 mg. **Uses:** Headache including migraine and tension headaches, toothache, neuralgia, backache, rheumatic and muscle pains, pain due to non-serious arthritis, dysmenorrhoea, sore throat and feverishness, symptoms of cold and influenza. **Dosage and administration:** *Adults and children, 12 years and over:* Two tablets up to four times daily. Not more than 8 tablets in 24 hours. *Children 6-12 years:* Half to one tablet up to four times daily. Not more than 4 tablets in 24 hours. Not more than 3 days use in children without doctors advice. *Children under 6 years:* Not recommended. Do not exceed the stated dose. **Contraindications:** Known hypersensitivity to ingredients. **Precautions:** Use with caution in patients with severe liver or severe hepatic impairment, non-cirrhotic alcoholic liver disease. Caution required in patients taking warfarin or other coumarin anticoagulants, domperidone, metoclopramide, cholestyramine. Not to be taken concurrently with other paracetamol-containing products. Use in pregnancy should be on doctor's advice. Not contraindicated in breast feeding. Arthritis sufferers should consult a doctor if they need painkillers every day. Sufferers from persistent headache should consult a doctor. **Side effects:** Paracetamol: rarely, hypersensitivity including skin rash; very rarely, reports of blood dyscrasias (not necessarily causally related). **Overdosage:** Immediate medical advice should be sought in the event of an overdose, even if the patient feels well, because of the risk of delayed, serious liver damage. **Legal category:** 16's, GSL, 32's P. **Product licence number:** 00071/5074R. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** Compack 16's £1.39, Carton 16's £1.85, 32's £3.15. **Date of last revision:** May 2006. Panadol is a trade mark of the GlaxoSmithKline group of companies.

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Pharmacy Champions

Cover: This week's Pharmacy Champion Joanna Peacham. Picture: Bartholomew/UNP Photography

Remote supervision a 'nightmare', claims MP

Pharmacy Show Sandra Gidley says pharmacy risks losing its unique selling point

Jennifer Rigby

Plans for futuristic pharmacies where pharmacists oversee the store via video-links are nightmarish, a leading MP has claimed.

Speaking at the Pharmacy Show at the National Exhibition Centre in Birmingham this week, Liberal Democrat shadow health spokeswoman Sandra Gidley said that pharmacy ran the risk of losing its unique selling point (USP) if remote supervision took off.

"The public really value the way that you can just walk in to your local pharmacy and get advice from a healthcare professional. It's not just a medicine production factory but a social service, and you can't knock that," she said.

Claiming that this social element was the USP of pharmacy, she added: "Remote supervision is not a vision – it is a nightmare."

Sandra Gidley: the public really value personal advice from pharmacists

However, Ms Gidley insisted that the principle of better utilising the skills of pharmacy technicians was a good one. "By all means, use pharmacy technicians, but only to free up the pharmacist in the pharmacy to provide other services," she said.

"I may be described as a bit of a Luddite but I believe remote supervision is a case of throwing out the baby with the bathwater," she concluded.

Sandra Gidley has slammed the RPSGB for failing to fulfil its leadership duties. "They won't thank me for this, but we need real leadership now. Nearly everyone I speak to says they don't feel represented by the Society," she said. She also cast some doubt on the Section 60 reforms. "It seems a bit 1984 to me – I fail to see why we have to report our speeding fines to the Society," she said.

Dunn hits six-point plan for future

Pharmacy Show AAH MD details coping policy

Pharmacists are not an automatic part of the future vision for the NHS. But there is much they can do to capitalise on government's desire to improve access to healthcare, said Steve Dunn, AAH group managing director, in a keynote speech at this week's Pharmacy Show.

There are six things pharmacists can do to cope with the "seismic change" in government policy, Mr Dunn said.

- Examine your attitude: "The requirements of pharmacy to increasingly follow a service provision agenda are not going to go away. Get used to it and accept it. Successful organisations are the ones that can change rapidly."
- Focus strongly on management: the dispensing technician role has to grow, to take responsibility for the basic functions of the pharmacy.
- Get the pharmacy structure right: get a consultation room, introduce a category management programme.
- Work on business relationships: "People buy from people and the business of pharmacy is no exception. You need to be talking to the doctors, working with them to define local health needs and at the same time keeping your eye on the PCT."
- Make the right business partners.
- Embrace technology: growth in volume of drugs will soon outstrip the handling capacity of individual pharmacists and IT solutions will be required.

Pharmacy needs to demonstrate to doctors, primary care organisations and other professionals that it can make a real contribution, and it can best do this by executing the new pharmacy contract. However, the average pharmacy handled only 1S MURs and 1.7 enhanced services during 2005-06.

Mr Dunn said: "If we drop this ball – if we fail to deliver – the chance will be lost forever. Other groups will grab the opportunity and the revenue stream, and pharmacy will be marginalised and condemned to inevitable decline." **AC**

Script charges come under review

Legislation Changes must be cost neutral

The Department of Health has pledged to review prescription charges. In a review to be completed next summer, the DH will look at issues such as revising the list of medical exemptions to prescription charges, introducing a flat rate charge with no exemptions and basing exemption to charges solely on income.

However, health secretary Patricia Hewitt has emphasised that any change will have to be cost neutral, disappointing the Commons select committee which has called for an end to all health charges.

Ms Hewitt also turned down the committee's call for a limited NHS formulary of medicines, possibly linked to reference pricing to reduce the drugs bill and improve prescribing practice.

- From July 1, 2007, patients will be able to buy 12-month prepayment certificates by monthly direct debit. And a three-month certificate will replace the four-month version. **AC**

AAH launches website in bid to derail Pfizer distribution deal

Pharmacy Show Online petition against UniChem tie-up

Ailsa Colquhoun

AAH Pharmaceuticals has set up an e-petition, which pharmacists and other stakeholders can use to register their protest at the recent Pfizer/UniChem distribution deal.

The petition website, www.savepharmacy.co.uk, is supported and operated by AAH. The aim is to send the names and any comments provided to the Department of Health and the PSNC, said Steve Dunn, AAH group managing director.

However, the companies leading the distribution deal urged contractors to approach them directly with any concerns.

David Coles, UniChem managing director, said: "Both Pfizer and UniChem are absolutely committed to engaging with pharmacy regarding these new distribution arrangements and both organisations are open to dialogue with any concerned parties."

Mr Dunn encouraged Pharmacy Show visitors to make their opposition vocal, either through LPCs, trade organisations or local MPs.

"We need to convince government that there are better ways to think about this. Otherwise your workloads will increase, the number of invoices you process will increase, your ordering will be made more complex, your profitability will suffer and you will be forced to invest in diversionary activities at the expense of delivering the contract."

Mr Dunn warned that the deal may prevent wholesalers from providing pharmacists with the current range of stock, services or discounts.

"Now is not the time to drive out competition and choice in pharmacy at the very time the NHS is seeking to increase choice and competition in healthcare delivery," he said.

Read Pfizer's response to pharmacy concerns See page 18 ›

Steve Dunn: failure to embrace new services means inevitable decline

Media spin: England cricket star, Monty Panesar catches up with C+D during this week's Pharmacy Show in Birmingham.

The left-arm spinner praised the profession and said he had enjoyed his show visit. "I always get a good service from my local pharmacies. I did A-level chemistry so am interested in the subject area," Mr Panesar told C+D.

The England ace provided autographs and a practice bowling session for show visitors. For more on the Pharmacy Show see p34

Tighter guidelines rolled out on CD record keeping and disposal

Medicines Post-Shipman guidelines will be reviewed during 2007

om Hawkins

uidelines to tighten up the dministration and disposal of ontrolled drugs (CDs) have been nveiled by the Department of ealth.

Final implementation guidance for ontractors in England on record-eeping for CDs has been published.

The changes, which were initially troduced in July, form part of the ost-Shipman changes to strengthen ie audit trail for schedule 2 CDs.

The guidance recommends that harmacists include in the CD egister a running balance of stock nd the name and professional gistration number of the dispenser.

The measures are designated as good practice, with the aim of them becoming mandatory when electronic registers are commonplace.

There will be a further review of the guidelines in 2007 to incorporate any changes resulting from the Home Office review of the CDR format.

The DH has also introduced interim guidelines on the safe disposal of CDs. It has broadened the groups authorised to witness CD destruction from senior healthcare officers to those directly accountable to an executive officer who are subject to a professional code of ethics. The witness must be independent of day-to-day supply of CDs.

PCTs have a responsibility to ensure they have sufficient witnesses to avoid build-up of expired stock, which creates crime prevention and waste management issues.

PSNC said the cost of extra CD administration relating to NHS prescriptions will be calculated retrospectively to give an accurate assessment of the cost to contractors.

This will be factored into next year's pricing negotiations.

• An updated version of the National Prescribing Centre's guidance to good practice in CD prescribing is scheduled for publication next month.

Minister rejects call to act on medicines pack sizes
See page 10

Methadone

London, Eastern and [illegible] Specialist Pharmacy Service has issued an alert on the strengths of methadone oral solution.

The alert to chief pharmacists says there are three strengths: 1mg/ml; 10mg/ml, and 20mg/ml. However, a prescription may only specify volume (ml) and this has resulted in higher strength preparations against scripts for 1mg/ml solution (methadone mixture DTF).

The alert recommends that prescriptions should clearly specify the intended dose of methadone in mg and not by volume (ml) alone.

Keep practising

The RPSGB Practice Committee, which was set to be replaced by the National Boards, will continue until at least May 2007.

At the Society Council meeting on October 10, it was agreed to prolong the life of the committee to ease the transfer of power to the National Pharmacy Boards for England, Scotland and Wales.

Armed with pliers

Pharmacy staff were left terrified last week when a man stormed into their Nottinghamshire pharmacy claiming he had a gun, which turned out to be a pair of pliers.

The man, said to be in his 70s, demanded drugs from the Alliance pharmacy in Ollerton, but was wrestled to the ground by a passer-by, arrested, and then later bailed.

Pre-reg conference

Places are still available at the BPSA Pre-registration Conference, supported by the PDA, on October 29 in Birmingham. The event, at the Burlington Hotel, runs from 10am until 4pm.

For information or to register, visit: www.conferenceevent.com

Weldricks in the loop

All 50 Weldricks pharmacies are now able to process electronic prescriptions using AAH's LinkEvolution IT system. They are using their N3 connection to exchange information via NHSnet and process electronic prescriptions to Weldricks.

'Super surgeries' not so super for pharmacists

Policy Industry rejects Lord Warner's demand for extra LIFT centres

Jennifer Rigby

More one-stop shop super health centres may not be good news for pharmacy, industry commentators have warned.

The comments come after health minister Lord Warner's demand for more local improvement finance trust LIFT centres.

Speaking at an NHS LIFT event, the health minister told delegates that GPs, health services and social workers must all begin to practise under one roof to bring the new patient-led NHS into the 21st century.

"The primary, community and social care of tomorrow cannot be delivered from the facilities of yesterday. It is only logical for these systems to be located on the same site," he said.

Lord Warner: wants to take a patient-led NHS into the 21st century

However, several commentators fear that pharmacists – and patients – may miss out under expansion. Steve Lutener, PSNC head of regulation, said: "The PSNC agrees with Lord Warner that the nature and location of services should be planned much more around the needs of the patient, but we do not believe that this means co-locating all pharmacies into one-stop centres."

MP Sandra Gidley added: "I'm worried that the government doesn't appreciate the value of the existing pharmacy network. I say: play with it at your peril."

For more on NHS LIFT see editor's comment on page 18 ›

Wholesalers hit positive

Wholesaling BAPW upbeat

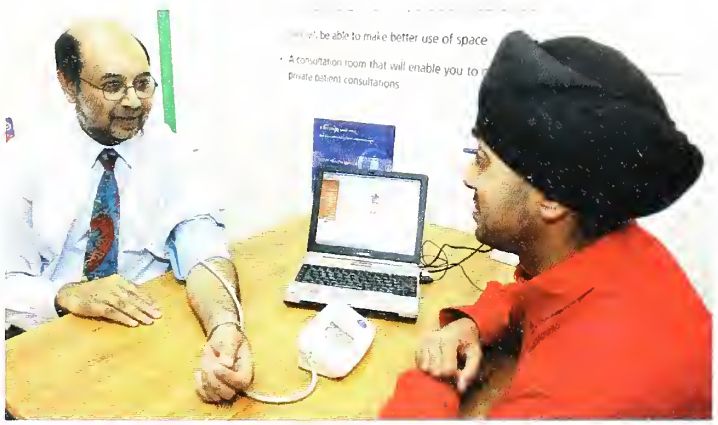
The British Association of Pharmaceutical Wholesalers is staying positive despite the furore over the Pfizer-UniChem deal and the resignation of their chairman.

At its annual parliamentary reception, new chairman Ian Brownlee of Mawdsley-Brooks focused on the 'gold standard' for delivery that BAPW is implementing.

"We are the invisible backbone of the NHS, and it is our reliable quality which is so important to our customers. Our aim is to continually improve our supplies to pharmacists, despite Pfizer's attempts to threaten this," he said.

However, a leading MP voiced concerns over the long-term future of the existing wholesale model.

Dr Howard Stoate expressed his view that logistics company DHL, which is to supply medical equipment and some drugs to pharmacies, is likely to expand further. **JR**



President put to the test: RPSGB president Hemant Patel receives a blood pressure check from Ajit Malhi, AAH professional services manager, at the Pharmacy Show launch of the Vantage health watch Men's Health Service.

The service, which comprises a half-hour check-up including body mass index (BMI) and blood pressure, cholesterol and glucose checks as well as a short lifestyle questionnaire, is designed to promote healthy lifestyles in men.

The package, which costs £80, is the 15th Vantage health watch service. It could be provided as an enhanced service, AAH says.

Fitness to practise standards to match other medical bodies

RPSGB Measures should protect the Register

If you don't sign the fitness to practise Register in time you will be struck off, the RPSGB has ruled.

In an overhaul of the rules regarding signing the fitness to practise Register and paying the annual fee, the Society decided to bring its standards up to those of other medical bodies.

From now on, the process will be the same as with the non-payment of fees: if you don't pay within two months of your final reminder, you will be taken off the Register.

The Society stressed that the measures were not necessarily punitive, but were being put in place to protect the Register.

The Society also concluded that the system for pharmacy technicians' fees would become the same as for pharmacists. **JR**

Fit for the job?

The shake-up in the fitness to practise regulations will not require pharmacists to provide medical evidence of their physical state, the RPSGB has concluded.

One of the criteria considered for pharmacists to be declared fit to practise was the provision of a medical certificate. However, the idea was rejected as unworkable.

Novartis goes direct with DHL

Industry DHL to supply selected hospital pharmacies

Drugs manufacturer Novartis Pharmaceuticals has signed an agreement with logistics firm DHL to deliver specialist medicines directly to certain pharmacy customers.

Under the terms of the deal, DHL will provide selected hospital pharmacies with drugs used to treat diseases such as cancer and for procedures such as transplants.

Novartis will continue to use the wholesale supply chain to provide its medicines to community pharmacy, but use DHL as its pre-wholesaler. The company said DHL will supply community pharmacies directly only on the "extremely rare" circumstances when supply is critical. **TH**

DDA wants merged register

Profession Details to be combined with RPSGB list

Dispensing doctors have called on the Department of Health to regulate technicians working in GP surgeries and to merge their register with dispensing staff in pharmacies.

In its response to the Foster Review, the Dispensing Doctors' Association points out that it has maintained a voluntary register of dispensing staff for some time. DDA chairman Dr Richard West said: "We believe there should be a single register based on qualifications, skills and experience rather than place of work. We believe our register upholds the best professional standards and would like it to receive official validation." **AC**

UniChem sees barriers to enhanced services

Practice Wholesaler submits views on future of pharmacy to APPG

Jane Ellis

UniChem has submitted its views on the future of pharmacy to the All-Party Pharmacy Group (APPG).

Following feedback from delegates to this year's UniChem Convention, the wholesaler has identified four key barriers to the successful development of pharmacy services.

The four barriers are:

- Uncertainty of funding.
- Lack of a clear enhanced services framework.
- The need for pharmacists to raise their profile with PCTs.
- The requirement for more resources and staff if pharmacists are to be able to maintain improved service provision.

On a more positive note, relationships between pharmacists and GPs have improved, although more could be done, concluded UniChem.

In addition, the introduction of pharmacists with special interests has given independents the opportunity to develop centres of excellence in areas such as diabetes, smoking cessation and mental health, said the wholesaler.

Priority areas for future development include medicines management, public health advice, patient health monitoring, repeat dispensing and prescription management.

Pharmacists could also become involved in minor surgery and laser treatment, family planning clinics and occupational health services, it said.

Chris Martin, chairman of the UniChem customer forums, said: "We believe this is a true reflection of the key issues and concerns that pharmacists are facing in this new era and we hope that our input will go some way to securing a more rewarding future for the profession."

Chris Martin: hoping to secure a more rewarding future for the profession

YOUR PHARMACY YOUR FUTURE

Health minister rejects standard size pack idea

Politics Not for government to dictate pack sizes, says Andy Burnham

Health minister Andy Burnham has rejected calls to pressure manufacturers to present their medicines in standard pack sizes.

In response to Tim Boswell, the Tory MP for Daventry, Mr Burnham said: "We are not convinced that it is for the government to tell manufacturers what pack sizes they should produce."

The minister added that any European Union law implications of such a measure would need to be considered. In any event, standardising the size of packs manufactured in the UK would not impact on packs imported from other EU countries.

In his written answer, Mr Burnham advised that the government was still considering whether to allow pharmacists a limited ability to alter the quantity prescribed in order to increase patient pack dispensing. This was mooted as part of the consultation on simplification of reimbursement arrangements for National Health Service dispensing contractors, launched last year. **CB**

Pfizer decision worries Numark members

Industry Fears that distribution agreement may affect discounts and deliveries

Members of Numark's Pharmacy Advisory Board (PAB) voiced their concerns about Pfizer's decision to distribute prescription medicines exclusively through UniChem, at its meeting in London.

They also discussed Numark's own-brand products, promotions and PIs.

PAB member David Gill, owner of three Numark pharmacies in Yorkshire, said: "There was great unhappiness about Pfizer's decision. The feeling was that it would have a severe and detrimental effect on the pharmacy supply chain and the discount clawback. It could also jeopardise the twice-daily delivery to pharmacies."

David Gill: Pfizer deal detrimental

It was suggested that Numark members write to Pfizer and encourage their local reps to contact the company. They should also make PCTs and GPs aware of their views. Numark will provide templates of letters.

PAB members also voiced concern that discounts on PIs were not very clear and asked that the net price of the PI line should be provided. **JE**

Update Knockout 2007 down to last 22

With three months to go there are 22 pharmacists left in the Update Knockout 2007. Of the hundreds who started in January, the 22 have maintained a 100 per cent record. As well as having something to put in their CPD portfolio, any of them could be in line for £2,000 from sponsor Genus pharmaceuticals, with £1,000 to the runner-up.

To find our winner, each finalist will have to answer three elimination papers based on the knowledge learned from this year's Update Modules. Good luck to:

- Julie Dubnewytsch, Dinnington, Sheffield.
- SF Howard, Sheffield.
- Jennifer Jones, Plymouth.
- AJT McNeilly, Corby, Northants.
- William Fisher, Gullane, East Lothian.
- Sheila Castle, Truro, Cornwall.
- Michelle Warner, Ashington, West Sussex.
- Coll Michaels, Watford.
- Trevor Purrington, Oxford.
- Maggie Vesty, Oxford.
- John Garner, St Helier, Jersey.
- Nicola Entwistle, Sittingbourne, Kent.
- Joceleyn Hughes, Sheffield.
- P Zafar, Mill Hill, London NW7.
- Fiona Marshall, Ransey, Isle of Man.
- Dhirajlal Solanki, Cambridge.
- Helen Ferguson, Felixstowe.
- Lynne Woodburn, Ingleton, Lancs.
- Raymond Hyde, Great Yarmouth.
- Catherine Gilchrist, Downpatrick, Co Down.
- David Entwistle, Sittingbourne, Kent.
- Andrew Leighton, St Annes, Lancs.

Go to www.dotpharmacy.com/knockout06.html for information.

Council agree to five-year R&D strategy

RPSGB Value of research recognised over cost

Council members agreed to accept in principle a five-year research strategy at October's council meeting. Spanning 2007 to 2011, the strategy has an increased research budget of £250,000 per annum, up from the current £200,000.

There was general agreement that the profession benefits from having a research strategy, but concerns were expressed regarding the cost.

The budget will be considered later in the year by the Resource Management Committee. **LR**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Your views

Independent thinking

Colin Brown finds the Conservatives and Labour at odds over the future of the NHS – but will it stay that way?

Independence for the NHS is the fashionable slogan for both David Cameron and Gordon Brown. But there are serious misgivings among some Labour MPs about its impact on community pharmacies.

Mr Cameron is proving a difficult target for Mr Brown to hit. And when Mr Cameron is not stealing Mr Blair's clothes, he is anticipating the Chancellor of the Exchequer. There is an argument about who was first, but both Mr Cameron and Mr Brown have proposed making the NHS independent.

This is fraught with dangers. Nye Bevan, the health minister involved in setting up the NHS, said: "If a bedpan is dropped in a hospital ward, I want the noise to reverberate through the corridors of Westminster." The Labour warhorse was wily enough to know that politicians at national level get the blame for local NHS closures.

There are also dangers for the service from making the NHS independent, which were quickly realised by Howard Stoate, the Labour MP and GP who chairs the All-Party Pharmacy Group.

Within minutes of Mr Brown's speech to the Labour conference, Dr Stoate told me he was concerned that independence for the NHS would translate into a postcode lottery in health. Surely, if the health service is made independent of national control, he said, it would lead to GPs in one part of England prescribing a drug that was not available in another.

> A full-scale propaganda war is being waged

I suspect that the idea will be modified before Mr Brown fully embraces it. However, it is part of a full-scale propaganda war being waged over the NHS at Westminster.

The Tories began the autumn offensive by launching a campaign attacking 'Brown's NHS cuts' last weekend. They also initiated a Commons debate timed to coincide with their offensive.

Most observers at Westminster were underwhelmed by the Tory attack, but it seriously rattled Labour. I discovered that Labour's resources unit at Westminster issued all Labour MPs with a rebuttal pack.

For those Labour MPs incapable of thinking for themselves, it said:

- David Cameron and the Tories have no credibility on the NHS.
- When they were in government, they starved the NHS of resources.
- In opposition, they voted against Labour's extra investment which has paid for more doctors and nurses, more operations, the lowest waiting times on record and more lives saved.
- And their policy of sharing the proceeds of economic growth between tax cuts and public spending would mean £17 billion of cuts to Labour's spending plans this year, including the NHS.

Labour MPs were also supplied

ith a dummy press release to send
o their local newspapers with a
uggested headline and a place for
he MP to insert his or her name:
*"<INSERT NAME> MP says "Don't
ll for Cameron's Con.*
"You can't trust the Tories on the NHS.
*"<NAME> MP today warned local
eople not to fall for David Cameron's
on on the NHS. Speaking ahead of a
arliamentary debate in Parliament on
he NHS <NAME> MP said: "David
ameron claims he cares about the
HS. But he must think the people of
INSERT AREA NAME> were born
esterday. David Cameron voted
gainst extra funding for the NHS
nd just last year wrote the Tory
anifesto which proposed a subsidy
r private patients."*

The Prime Minister also underlined
he concern in Downing Street by
evoting the start of his monthly
ress conference to NHS delivery – or
he failure of it – on Tuesday before
eeting strategic health authorities.

The Tories are largely ignoring Mr
lair, however. They see him as the
eal target and are seeking to destroy
im on his safest ground, the public
ervices, before he has a chance to hit
ack with the authority of the Prime
inister's office that he covets.

**olin Brown is the deputy political
ditor of The Independent**

Give Pfizer the benefit of the doubt

There is no question that Pfizer's decision to distribute its products through one wholesaler in the UK has caused major concern to many, both in community pharmacy and in wholesaling. However, Steve Dunn's eagerness (C+D, October 14, p16) to predict all types of upheaval when this commences does nothing to help the situation and only muddies the waters further.

As far as I am aware, AAH was one of many parties to be approached by Pfizer to provide this service and, as we know, UniChem was chosen because of its ability to deliver this service throughout the country. I believe that this was confirmed by independent consultants as part of the tendering process and I am afraid Mr Dunn's protestations therefore smell suspiciously of sour grapes.

It is also unfounded to claim that Alliance Boots is now going to concentrate on its own outlets at the expense of its independent customers. Since they still far outnumber its own outlets, it would be foolish to ignore them or provide an inferior service. If I don't like the service I receive from UniChem I can take my business elsewhere.

Strong support for its independent customers has been made patently clear by senior Alliance Boots board members such as Richard Baker, Stephano Pessina and Ornella Barra. Let's not forget that Lloydspharmacy is AAH's retail partner; does Mr Dunn then give preferential service to Lloydspharmacy?

Indeed, I have to say that since the merger, I have noticed no deterioration in UniChem's already excellent levels of service and if anything we are starting to see that its price offering is becoming even more competitive. We were told before the merger that the new company's greater buying power would benefit all their customers and this certainly seems to be the case.

Change is inevitable in our profession and industry and I am relieved that the Pfizer distribution model is to remain within pharmacy

I am relieved that the Pfizer distribution model is to remain within pharmacy

when Boots [illegible] UniChem rather than [illegible] swallowed up by one of the [illegible] groups. It is because of Alliance Boots' increased presence in the market that it feels able to deliver this new service and retain it within the pharmaceutical wholesaling domain.

As for Pfizer, it initiated this, not UniChem, nor any other wholesale group. Let's see what it has to offer us and let's not speculate or spread unfounded alarm throughout the profession. I suspect that we are in for enough upheaval without trying to dream up more.

James Allan, community pharmacist, Scotland

Editor's note: Mr Allan is chair of the UniChem Scottish Customer Forum but is writing in a personal capacity.

Pharmacy Champions

Pharmacists leading the way

Joanna Peacham's stop smoking service is funded by Hull PCT and offers six weeks of one-to-one support to would-be quitters

Name
Joanna Peacham

Pharmacy
Brocklehursts Chemists, Hull

What has she done?
Runs a stop smoking clinic

What have you set up?
We are one of the pharmacies funded by Hull PCT to provide a six-week programme of one-to-one support to smokers trying to give up. The programme includes preparing to quit, information on NRT and Zyban, quit day preparation, the benefits of giving up, lifestyle change and coping strategies to minimise relapse. Carbon monoxide readings are taken at each attendance. It's been running for just over two years and we've seen more than 100 clients. More than two-thirds have stopped smoking.

What has been the high point?
The benefits to patients – it's a great feeling when people pop in to say they are still doing well. Our clinic is more flexible than a group session as there's no waiting list and appointments can be made at any time when the pharmacy is open, including Saturday, which means it suits everyone whether they need to fit the sessions around childcare, shiftwork or other commitments. Some clients find it helpful to quit at the same time as a relative or friend and in these cases we'd see them both together. They can also come in for advice or a bit of encouragement between sessions. It's increased my confidence about my health promotion role and ability to motivate people.

And the low point?
I find it frustrating sometimes, particularly with reluctant clients who have been forced to attend by their GP. I have to persuade them that I'm guiding them, not giving up for them. I try not to take it personally if they do not give up. Funding is limited to 50 clients a year so we are unable to advertise the service widely. It needs to be properly evaluated to show the benefit of the one-to-one approach as it is more costly to the PCT than group sessions. As we've seen nearly 50 people already this year, I would like to ask the PCT if we can take more clients if the other pharmacies in the scheme haven't reached their quota.

What has been the response from patients and GPs?
It's been well received and the fact that the patients return to the clinic for the full six weeks tells us we're doing something right. They wouldn't recommend the clinic to their friends or relations if it was rubbish. They're so pleased when they give up and often buy us chocolates and presents or send us cards to show their appreciation. Local GPs are increasingly referring people as they are recognising that this kind of specialist support increases quit rates.

Has it given you greater job satisfaction?
I've learnt a lot about how to carry out a consultation. I've developed skills that are also useful for MURs, which we started doing in August. I'm enthusiastic about the service and I've been trying to motivate the staff to get involved. Two technicians have recently attended the training with a view to taking over the running of the clinic and I hope they'll find the experience as rewarding as I have.

Nominate your Pharmacy Champion:
Telephone 01732 377688
or email chemdrug@cmpmedica.com

DON'T PHARMACY

Pfizer's decision to introduce a single distribution channel could hit pharmacy where it hurts.

Help save pharmacy and protect your independence by visiting
www.savepharmacy.co.uk

Your views

Category M pricing – it doesn't add up

Mimi Lau, director of professional services for Numark, does the sums

Category M was introduced in 2005-06 as part of the funding arrangements for the new pharmacy contract – primarily as a mechanism to allow the Department of Health to recover a proportion of pharmacist purchase profits.

The negotiations resulted in agreement that £300 million would be removed from retained profits on generic products.

Category M prices are adjusted quarterly aiming to remove £75m each time. Where there is any over or under recovery, adjustments are made as part of the quarterly review.

As manufacturers and wholesalers are required to submit pricing information to the DH every quarter (every month for off-patent products) the theory was that this would provide some stability in the market as well as price transparency compared to the old system.

The first quarter with the new category M arrangement was a disaster. Less than £75m was removed due to issues with amlodipine shortages, which hadn't been recognised by the DH.

As a result, more money had to be removed from the second and third quarters and therefore the system designed to prevent the wild fluctuations in reimbursement has actually had the opposite effect.

Indeed, these quarterly adjustments have resulted in many pharmacists being unable to predict profits accurately and therefore invest in their businesses. The question now being asked by many pharmacists is: will this situation recur again? And how can we ensure that adjustments made each quarter are kept to a minimum?

I want to know how much was actually removed during 2005-06. Was £300m removed and was £500m retained in generics purchase profits as promised at the beginning? And are statistics available that can tell us?

It certainly seems that category M has led us to a situation where we can no longer be confident that the initial aims are still the same today.

Part of the £300m being removed from purchase profits was always to be given back to contractors in the form of practice payments and payments for advanced services.

Pharmacists are supposed to be able to make up some of the deficit in their income from MURs. But it was always unreasonable to expect contractors to start providing MURs from the first day of the new contract – pharmacists had to get themselves and their premises accredited – so they were playing catch up straight away.

This is a particular issue for independents who just don't have the resources of the multiples at their disposal. Two hundred MURs would always be a challenge and this was further compounded by problems with GPs' and patients' lack of engagement.

Let's compare it with the minor ailments scheme in Scotland – the SEHD took full responsibility for informing patients and healthcare professionals and undertook a national campaign. A great example of the government working with pharmacy. Why was this not done in England and Wales with MURs?

How can we ensure that adjustments made each quarter are kept to a minimum?

If we could go back, what could we have done to ensure better buy-in from all stakeholders including pharmacists? As a result, many did not deliver the full 200 – but no allowance was made for this.

Forward planning

With regards to funding for the second year of the contract, contractors had to wait until September before funding arrangements were announced. How on earth can you plan a business without knowing what you are going to be paid? Would this happen in another industry?

The result is that another £150m is to be removed from October 1, 2006. This brings the total to £450m to removed in this second funding year.

Was it not the case that only £300m profit would be removed from category M or was it £500m to be retained in the first place? This was never really made clear.

The initial target of removing £300m from generic purchase profits was always based on the assumption that £500m would remain and there was always an expectation that this would be monitored.

However, no monitoring of profits was undertaken in the early part of 2005-06 and monitoring was only undertaken for 42 pharmacies in October 2005 and February 2006.

There seems to have been no rationale for the number, selection of pharmacies chosen or transparency in the interpretation of the data. Indeed PSNC has said that it has substantial concerns relating to the interpretation of the data.

The critical question here remains – was the initial aim of category M to remove £300m or leave £500m?

Given the changes announced from October onwards it would appear that the initial calculations were significantly flawed.

So what will be the likely impact on pharmacy viability of the changes to category M?

Pharmacists will be compensated in part by increased funding on MURs. Yes, no doubt now financially viable – so for those contractors who have yet to engage they may now be motivated to do so.

However, this is a very stretching target – 400 a year, or on average two per working day, is quite hard to achieve.

There is no doubt that pharmacists will require good planning and implementation – not to mention robust systems to free their time in order to hit the number. Will we end up with egg on our faces if the majority of us don't deliver the required number? Would we not have been better increasing the value per MUR beyond the £25 (previously £23) and putting some cash into promoting it to patients and GPs?

In practice, individual pharmacy income and profits will vary according to the size and mix of business and margins achieved. Single contractors could potentially be most adversely affected unlike groups where margins and income can be balanced by the mix of pharmacies within the group.

A final thought – how will this new funding affect contractors in Scotland as they have been following England and Wales on category M prices since April this year? Will their contract be sustainable?

And why did Scotland follow England and Wales in the first place when everything they have done is different – no control of entry, different pharmacy contract based on different services and methods of payment (eg capitation fees).

Priyesh Desai, a Numark member with two pharmacies in Essex, said: "I have just worked out my potential losses and just in one of my pharmacies I will lose £28,000 over the course of a

As a healthcare professional you want to steer parents in the right direction when you recommend an ibuprofen for their children. Calprofen not only works in 15 minutes to reduce fever and lasts for up to 8 hours, it also provides a little added extra – the reassurance that parents are looking for. Give them Calprofen, ibuprofen from the makers of Calpol. Now that's a relief.

Contains ibuprofen

Ibuprofen for kids. Peace of mind for parents.

Calprofen Product Information: Presentation: Suspension containing 100mg Ibuprofen per 5ml **Uses:** Treatment of mild to moderate pain and as an antipyretic and post-immunisation pyrexia. **Dosage:** *Infants 3-6 months:* One 2.5 ml dose may be taken 3 times in 24 hours, Infants 6-12 months: 2.5ml three times a day; *Children 1-2 years:* 2.5ml three to four times a day; *Children 3-7 years:* 5ml three to four times a day; *Children 8-12 years* 10ml three to four times a day. Post-immunisation fever: 2.5ml (50mg) followed by another 2.5ml (50mg) dose six hours later if necessary. No more than 2 doses in 24 hours. Not recommended for children weighing less than 5kg **Contraindications:** Hypersensitivity. History of peptic ulceration. Individuals in whom Ibuprofen, aspirin or other non-steroidal anti-inflammatory drugs induce asthma, rhinitis or urticaria. **Precautions:** Hepatic or renal dysfunction, heart failure. Individuals with coagulation defects or receiving anticoagulant therapy. Caution in bronchial asthma or allergic disease. Care should be taken with antihypertensives including diuretics, cardiac glycosides, lithium, [illegible] cyclosporine, mifepristone, other analgesics, corticosteroids, anticoagulants, quinolone antibiotics, [illegible] **Pregnancy and lactation:** Not recommended. **Side effects:** GI disturbances, occasionally gastric [illegible] bleeding, hypersensitivity reactions and oedema. Other reactions that haven't necessarily been related [illegible] include renal and liver problems, neurological and sensory disturbance, haematological disorders and GI [illegible] **RRP (ex-VAT):** 200ml bottle £4.84, 100ml: £2.97 **Legal category:** 200ml: P, 100ml: GSL **PL holder:** 200ml: Pinewood Laboratories Limited, Ballymacarby, Clonmel, Co Tipperary, Ireland **PL number:** 04917/[illegible] **PL holder:** 100ml: Pfizer Consumer Healthcare, Walton-on-the-Hill, KT20 7NS **PL number:** 15[illegible]/[illegible]/[illegible] **Date of preparation:** September 2006

At 2 months, trust is everything

Trusted by healthcare professionals and parents alike, Calpol Infant Suspension (paracetamol) is licensed to treat pain and fever in babies from just 2 months. No other children's medicine is licensed in children this young – but then

no other children's medicine is backed by 40 years of gentle, effective relief. Now, Calpol lets parents treat even earlier when it comes to infant pain and fever. Simply make the most reassuring recommendation you can.

Contains paracetamol

Calpol Infant and Sugar-free Infant Suspension Product Information:
Presentation: Suspension containing 120mg Paracetamol per 5ml **Uses:** Treatment of mild to moderate pain and as an antipyretic **Dosage:** Children 1 to under 6 years: 5 – 10ml; Repeat dose every 4 hours if necessary, up to a max of 4 doses in 24 hours. Children 3 months to under 1 year: 2.5 – 5ml; Repeat dose every 4 hours if necessary, up to a max of 4 doses in 24 hours. Infants 2-3 months: Post –vaccination fever at 2 months: 2.5ml and a second dose, if necessary, after 4-6 hours. Treatment of mild to moderate pain and as an antipyretic (Infants over 4kg, not born before 37 weeks): 2.5ml and a second dose, if necessary, 4-6 hours later **Contraindications:** Hypersensitivity **Precautions:** Caution in severe hepatic or renal impairment. Interaction with domperidone, alcohol, metoclopramide, colestyramine, anticoagulants, anticonvulsants and oral contraceptives. Do not give with other paracetamol-containing products. **Pregnancy and lactation:** Consult doctor before use. **Side effects:** Rare: Hypersensitivity including skin rash; blood dyscrasias. Hepatic necrosis and papillary necrosis have been reported following prolonged use. See SPC for further details. **RRP (ex-VAT):** 100ml bottle: £2.30; 200ml bottle: £3.79, 12 x 5ml sachets: £2.71; 20 x 5ml sachets (original only): £4.36 **Legal category:** 200ml bottle: P; 100ml bottle: GSL; Sachets: GSL. **PL holder:** Pfizer Consumer Healthcare, Walton-on-the-Hill, KT20 7NS. **PL numbers:** Infant suspension: 100ml bottle: 15513/0122; 200ml bottle, sachet: 15513/0004, Sugar-free Infant Suspension: 100ml bottle: 15513/0123; 200ml bottle, sachet: 15513/0006. **Date of preparation:** September 2006

year. I think we have been lulled into a false sense of security over the last year and this is really what the new contract is going to mean for us. The honeymoon is over.

"I feel very aggrieved. I've put a lot of time and effort into training staff, ensuring we have the right protocols in place and developing the new services that are required. I expected to move with the times and develop everything required by the new contract. And I have delivered it.

"We are now faced with a massive loss that cannot be made up by MURs. There is no way an independent can cope and I feel our negotiating bodies have a lot to answer for.

"I've read in C+D about the new prices and they are just presented as fact and do not appear to have been challenged. There is no response from the PSNC; they seem to be oblivious to the whole thing. When people work out the implications on their business, they will be shocked. I have stuck to the letter of delivering this new contract but this is what I stand to lose."

Putting doctors in their place

To read that rural doctors who provide a supply-only function for NHS prescriptions are worried about the competition from 100-hour pharmacy opening exposes these practices, which operate in urban surroundings, for what they are. If they were really rural, such urban pharmacies, which offer the full range of pharmaceutical services, would be remote and miles away.

Their seven days' extended hours are the complete opposite and an anathema to the five-day weeks and reduced office hours that the vast majority of rural doctors offer. Ask their full-time employed patients about the extreme difficulties they experience in collecting their repeat prescriptions out of normal working hours!

Having traded a mere £6,000 for a drastic cut in their hours, rural doctors have seen their incomes soar by over 30 per cent to in excess of £115,000 and they now have the gall to demand to sell OTC medicines.

In reality these expensively trained doctors prefer a monopoly in choice

In cuddling up to these avaricious rural doctors, community pharmacy must not be hypnotised away from these facts and must also remember that over 11 per cent and increasing of all NHS prescriptions are made in this supply only function.

It is apparent from this latest protestation that rural doctors prefer a monopoly in choice; unfortunately for them the tide of freedom of choice is running against them as patient choice is now becoming paramount.

In reality these expensively trained rural doctors should do just that, namely diagnose and prescribe and leave the provision of a full pharmaceutical dispensing service to the acknowledged practitioners, namely community pharmacists.

JD Thomas, Patshull, Shropshire

PSNC responds...

Sue Sharpe, chief executive:
PSNC has stated publicly that it has substantial concerns relating to interpretation of the profit monitoring data, but accepts that unless prices changed there would be a substantial excess of purchase profits above the level agreed of £500 million. We continue to discuss our concerns with the DH. The purchase profit income provided as part of the new contract funding arrangements is subject to monitoring and adjustment, and as part of the arrangements we agreed that levels of profit reflect independent contractors' ability to secure those levels. This is set out in the new contract book published in 2004. In the first year, 2005-06, the only adjustment made was the removal of £300m to fund some of the new allowances, but in 2006-07, and in future years, adjustments will be made in the light of market information.

Comment from the editor

When will pharmacy be treated the same as GP surgeries?

The top level story surrounding LIFT (local improvement finance trust) projects sounds a good one. Health minister Lord Warner wants to see more of these 'super-centres'. One-stop shops for healthcare seem to make sense: why not just go to one place for your GP appointment, prescription and while you're there get your physiotherapy session and your feet done too? But, as ever, the devil is in the detail.

Pharmacy LIFT hasn't been a particularly good story. Even the National Audit Office has admitted that pharmacy has been treated like a business under LIFT. Unlike GP surgeries and dentists, which receive some reimbursement for their rent, pharmacies pay full rent. "Pharmacy, however, is likely to be the most significant source of third party income," says the NAO report.

It is at the discretion of a PCT whether pharmacy is considered as a primary care provider or not. Trusts can't have it both ways. Either they want pharmacy to take control of chronic disease management, MURs, provide EHC, smoking cessation clinics and all the other advanced and enhanced services anticipated in the new contract, or they want our money.

When will the wider healthcare community recognise that pharmacies and GP surgeries are both areas of business: contracted by the NHS to provide services? Cannot OTC sales and private GP practice business such as prescriptions and sick notes be comparable? How can such a system as LIFT be good for everyone, if all parties are not equal beneficiaries?

MP Sandra Gidley is worried that the government doesn't appreciate the value of the existing pharmacy network. The debâcle over domiciliary oxygen demonstrated this. Pharmacy has proved its value, its convenience and the loyalty of its customers. Why create prescription factories in out of the way places that would require a special journey and make pharmacies on the high street less viable?

This government's mantra is 'patient choice'. Has Lord Warner asked patients where they would like to pick up their repeat prescriptions? Play with pharmacy at your peril, indeed.

> When will the wider healthcare community recognise that pharmacies and GP surgeries are both areas of business

Your views

Answers to those burning questions

Dr Olivier Brandicourt, Pfizer managing director, defends the company's decision to choose UniChem

When Sir Walter Scott famously wrote "O what a tangled web we weave, when first we practise to deceive", he could easily be foretelling AAH's extreme reaction to our recent announcement.

This is a big change for us and for pharmacy, and clear, factual communication is required; not the thinly disguised 'save AAH' campaign designed solely to protect its own commercial interests.

We are very aware that there is much misinformation being spread in order to confuse and create unnecessary concern amongst contractors, and I want to address a few of those issues here:

- Counterfeit medicines? We know of at least eight recent breaches of the legitimate UK supply chain involving thousands of fake medicine packs circulating and reaching patients. The real volume of counterfeits is unknown, but we believe this is the tip of the iceberg and is growing. Our patients rely on our medicines; there is no room for complacency or counterfeits. Our change will provide a secure channel for pharmacists to be confident that when they dispense a Pfizer medicine, it is just that.
- Preferential treatment for Boots? I can guarantee this will not happen; UniChem is not acting as a wholesaler, it will store and deliver medicines on our behalf. A pharmacist with one shop will be treated in the same way as one who is part of a national chain. Unlike national wholesalers, we do not have the needs of a wholly owned pharmacy chain to consider.
- Continuity of supply? Recently the supply chain has been ineffective in managing stock shortages. During last year's Cardura XL supply issue, when some pharmacies couldn't obtain supplies and patients were unable to get their medicines, some wholesalers still had significant volumes. With our new arrangements we will be able to manage supply to meet demand fairly.

Pharmacists may have other concerns over these changes, and we are keen that they contact us directly. We have put in place many different ways for this to happen and we encourage all pharmacists to go to the website – www.pfizerdtp.co.uk – or use our dedicated telephone line, 0845 608 8866, and enter into a dialogue with us, rather than let a disgruntled wholesaler misrepresent both our intentions and your views.

> UniChem is not acting as a wholesaler, it will store and deliver medicines on our behalf. A pharmacist with one shop will be treated in the same way as one who is part of a national chain

Xrayser

Nothing but a talking shop

It's much easier to talk than to do, but the increasing use of aspirational clichés and buzzwords suggests too much wishful thinking and not enough action. If only one led to the other then everything would be dandy, but a quick analysis of some commonly used expressions suggests we should stop dreaming and get real.

The often hankered for, and probably mythical, 'level playing field' is a fantastical place dreamt of by those with a chip on their shoulder. If you are at the top end of the current steep incline then you never mention the level version in an attempt to ensure it remains a harmless piece of fiction.

And I often wonder how the imaginary 'unified voice' of the profession might sound. It's like forming a new group from the disparate sounds of the Sex Pistols, Will Young and Black Sabbath – who on earth would listen to that dreadful racket?

Everyone has their own map showing the 'future direction for community pharmacy', so it's no wonder that we all keep getting lost. Maybe we should get some cartographers in to show us the way.

But to agree on that we would need to employ 'collaborative working' and form some 'strategic alliances'. But not many people want to form strategic alliances with us because, after all, we're too often seen as 'simply shopkeepers'. And who wants shopkeepers in the 'primary healthcare team'?

This team doesn't need any more members anyway because it's very successful with a GP playing every position. I think a pharmacist made an appearance as substitute once, but a nasty tackle forced him out of his 'professional role'.

Perhaps it would all come good if only we had some 'ring-fenced funding'. Whatever a ring fence might be, I won't get one in my garden because the dog would be sure to escape through such a porous barrier. We must be less fussy because any sort of new funding would be brilliant – ring-fenced or not.

But if we were to adopt the 'use it or lose it' approach we might be able to grab the funding before it disappears back through the gaps in our ring fence. And if it wasn't for our 'lack of engagement' with those on the other side of the fence they might send a little back in our direction, giving us something like a 'fair return'.

Xrayser C+D

DDA could have final say on Pfizer deal

Hopefully the increasing groundswell of discontent against Pfizer's new distribution arrangements will weaken its resolve.

This time though, we have a particularly powerful ally in an unexpected quarter. It's not often that we have the Dispensing Doctors' Association on our side but they could help swing it for us (C+D, October 14, p6).

This group has around 20 per cent of GP principals in its ranks and the ultimate power of refusing to prescribe Pfizer products. If all DDA members carry out their threat, Pfizer would have to reconsider.

Worrying times

October 1 may well have been a landmark in community pharmacy and primary care:

- New PCTs taking the field, but a few umpires (LPCs) complaining of ball tampering.
- The transfer of the oxygen service finally being forced out of the other side of the vortex, but many lingering concerns for patient care.
- Confirmation of the outcomes of negotiations on remuneration, but the devil is in the detail.
- Pfizer creating tidal waves with its announcement on distribution arrangements.

With new PCTs commencing their reign, but with so little in place and many outstanding questions around governance related to professional representation and commissioning, there is much to be done for LPCs to ensure a level playing field.

The DH is finally insisting that contractors for the new home oxygen service do what it says on the can, but community pharmacists who have cared for their patients with passion and professionalism for many years have serious concerns.

The DH is finally insisting contractors for the new home oxygen service do what it says on the can

The outcomes of the funding of the contractual framework have been broadly welcomed, but we await the detail and there are some concerns over the balance between the £89 million increase in the global sum and the £300m additional clawback on retained profit through category M. What is satisfying is the increased emphasis given to MURs. I just hope that contractors see the light.

Pfizer's announcement of its exclusive link with one wholesaler demonstrates the commercial fragility of our branch of the profession. Having begun to recover from a second body [illegible] from GSK, this uppercut [illegible] unwelcome and has [illegible] of discontent among [illegible] prescribers and PC[illegible] management [illegible] expect a signific[illegible]

Written by an L[illegible]

Your views

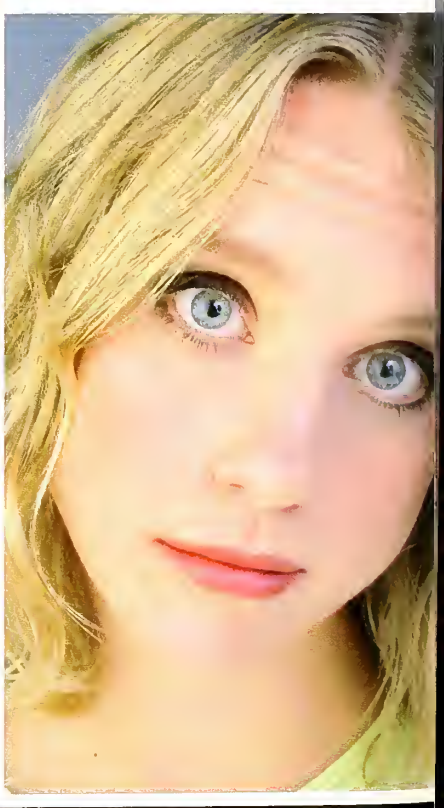
Smoothing over the cracks

Terry Maguire is looking for support for his 'Botox on Prescription' campaign

I was considering the gross injustice of it all – the blatant intolerable inequality – when suddenly I realised that Botox is already VAT-free. Things aren't as dire as I first thought and there is, I realised, hope that my new campaign can push for much more. VAT-free is only the first step. Why, I want to know, do decent, hard working people not get Botox on the NHS? I mean, they pay the tax that pays for the bloody NHS in the first place. Others get the medicines and services they need totally free, such as Viagra, Xenical and cosmetic surgery, so why not Botox? After all, Botox is a modern necessity so I have been asked by a commercial interest with a profound public interest in this matter to organise the campaign. My sponsor, like all big political donors, will remain anonymous but has agreed to pay me a suitably fat fee as long as I make a convincing case for free Botox on the NHS.

So I've started work on my "Botox on Prescription" campaign and it's not proving very difficult. The main plank of my argument is that certain people denied access to Botox through, say, their inability to pay, could feel very, very bad about themselves and their body image and suffer a total collapse in self-esteem. This might result in an emotional upset that in some cases could lead to severe clinical depression, and pharmacists will be well aware of the consequences of depression on our fragile society.

Let's pretend for a moment that you're a yummy mummy, SUV-driving resident of BT9 (or Culmore Road if you're unfortunate enough to live in the north west). If you are, you will know that you simply can't drive around having coffee and doing lunch with a face like a geophysical map of the French Pyrenees. No. Therefore you have a proven clinical need for six-monthly Botox, yet the miserable health service won't help. I know some might argue that if they were able to live in BT9 they could well afford six-monthly Botox facial injections. However, this logic is unfair and it's just the kind of biased argument that leads to social inequalities and injustices. And anyway, smokers seem well able to afford the cigarettes that clog their arteries and lungs yet there's no huffing and puffing about nicotine patches on prescription.



Look, it's simple: Botox is a medicine with a genuine medical indication so it's only reasonable that it should be available on prescription. It's safe. It must be. Did you ever hear of anyone dying of Botox injection overdose? Didn't think so. Severe facial paralysis with an inability to open one eye and severe problems retaining saliva in the mouth maybe. But death? No. OK, Botox's single indication, detailed in its SPC – the SPC each Botox user reads before having the toxin injected into their old leathery face – is for the management of some totally rare muscle spasm condition that, if it exists at all, only occurs in one person every 300 years. Come to think of it Botox must be the only licensed medicine that has never been used for the condition for which it was first licensed. But that only goes to prove that doctors who sign Botox prescriptions and kindly supply and administer the medicine, after undertaking a full and thorough medical examination of each patient, are the sort of practitioners that go that extra mile for patients. They prescribe Botox "off-licence" and in doing so take full liability should anything go wrong. Now that's not your normal GP.

And how could anyone question the obvious benefits of Botox? The benefits are so in your face. The sheer joy, the uplifting thrill of that first glance into the mirror and seeing, reflected back, that smooth, shiny, porcelain, youthful beauty. Admittedly the comparison with porcelain is rather apt as the face can feel slightly hard and cracking a smile can be difficult. But that's not such a problem, as the majority of Botox users were told years ago that smiling causes wrinkles, which simply cannot be tolerated.

So, all things considered, I think my lobbying over the coming weeks and months for the availability of Botox on prescription will be successful. There is a clear public health need for wider availability of this medicine and the benefits are clear: the more beauty there is, the happier people are and it is happiness, or lack of it, that is central to the health of our nation.

I have not yet completed my cost-benefit analysis for Botox but I have developed a Wrinkle Scale Measure (WSM) and started some research. WSM is a numeric measure with a baseline of the average 30-year-old non-smoker (the smoker's baseline is 25 years). It's a complex measure, but, put simply, the more wrinkles, the greater the score. Anyone with a WSM of more than one point above the baseline (smoker or non-smoker) should, according to my analysis, be allowed Botox on prescription. My preliminary results suggest that for every £1 spent on Botox there will be a £2 benefit in increased personal happiness. My data was collected by a validated questionnaire [illegible] patients suggested [illegible] which of course is nonsense.

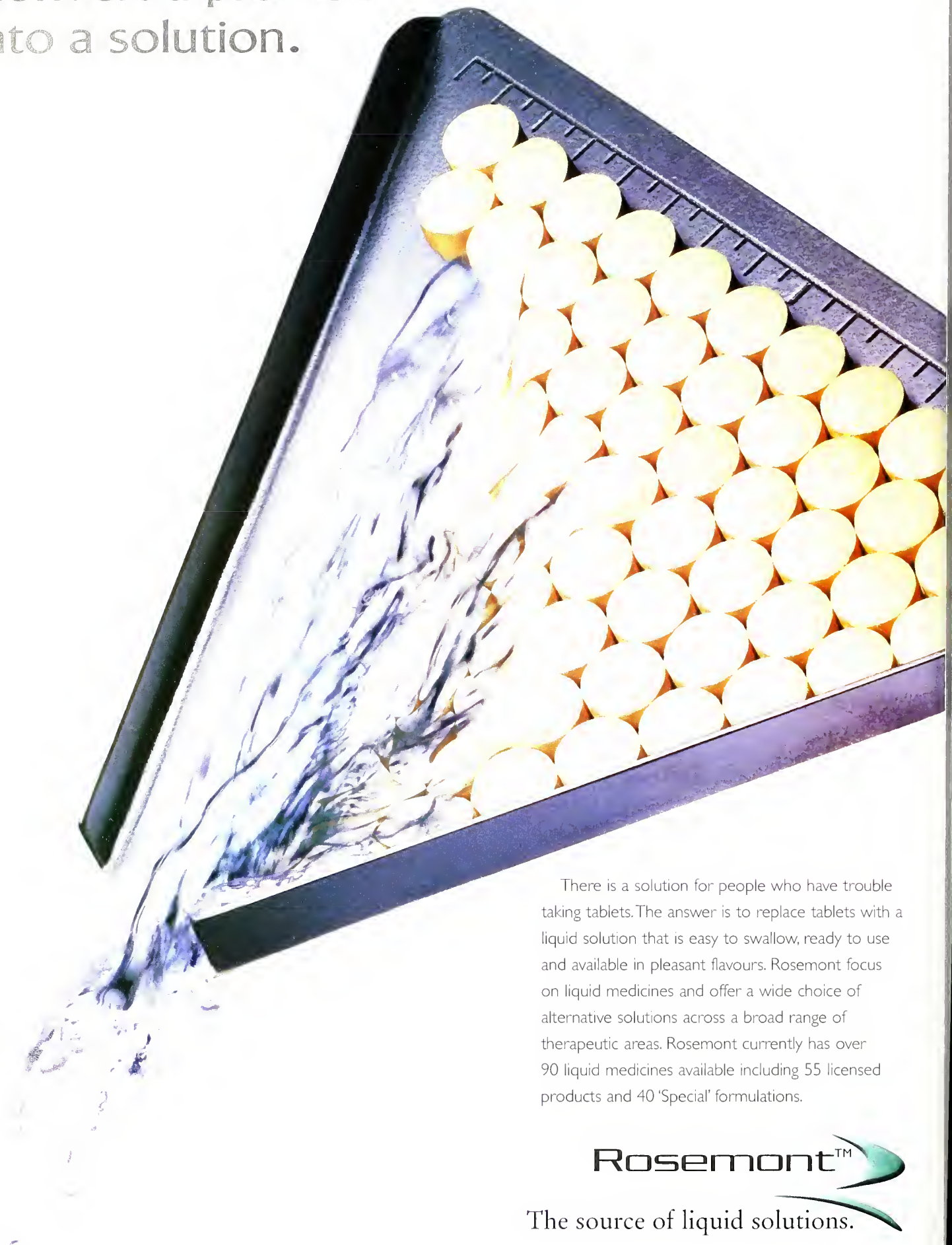
As I've said, Botox is [illegible] and access to it can only be b[illegible] thus the transaction is VAT-free. [illegible] Exchequer and indeed the health [illegible] more of this major benefit and their generosity [illegible] sponsoring public health. In the next election I can see this issue attracting considerable votes for Mr Brown. VAT-free is only the first step: Gordon must support "Botox on prescription".

I am asking all readers to support this essential campaign. If you are truly passionate about public health and committed, as I am, to ensuring people are happy and therefore healthy, how can you disagree? Let's hear you shout it: "Botox on prescription!"

If you'd like to lend your support to Terry's Botox campaign, email chemdrug@cmpmedica.com

Brow beaten: wrinkle free could mean worry free!

Convert a problem into a solution.



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C+D Clinical

Down in the mouth

C+D considers mouth ulcers, oral thrush and more sinister oral lesions

Paul Rutter

Community pharmacists often encounter patients who have symptoms suggestive of oral ulceration or thrush. Mouth ulcers, also known as aphthous stomatitis, aphthous ulcers or canker sores, include a variety of clinical presentations of superficial painful oral lesions that occur in recurrent bouts at intervals of a few days to a few months. Oral thrush (pseudomembranous thrush) is an opportunistic infection mostly caused by *Candida albicans* that presents as discrete white patches.

Both conditions should offer straightforward diagnosis provided pertinent questions are asked and the mouth is examined (see Panel 1 on how to do this). Key features of oral ulceration and thrush are shown in Table 1.

Differential diagnosis

The vast majority of oral lesions seen by community pharmacists will be ulcers or one-off trauma-related injuries from sharp teeth, biting the side of the mouth etc. However, it is the pharmacist's role to exclude underlying pathology predisposing patients to thrush, establish if risk factors are present and ensure symptoms are not due to sinister pathology.

There are many conditions that can present with oral lesions as a major symptom (Table 2). Questions centred on the nature and location of the lesion(s) should enable these to be eliminated (Table 3 – see page 26).

Ruling out oral lesions requiring referral

Patients who present with symptoms other than oral lesions should alert the pharmacist to pathology needing referral. Erythema multiforme and lichen planus are characterised by lesions of the skin as well as the mouth.

The skin lesions in erythema multiforme are sudden in onset, annular and affect the extremities. Infection and adverse drug reactions (such as sulfonamides, penicillins and phenytoin) are known to precipitate the condition. Oral ulceration is common and tends to be widespread. In contrast, oral involvement of lichen planus resembles oral thrush with raised white lesions. However, the lesions tend to be more spiderweb-like and patients develop psoriasis-like skin lesions.

Behcet's Syndrome is a rare condition and ulceration also affects the skin and genitalia, as well as causing 'red eye' (eg uveitis).

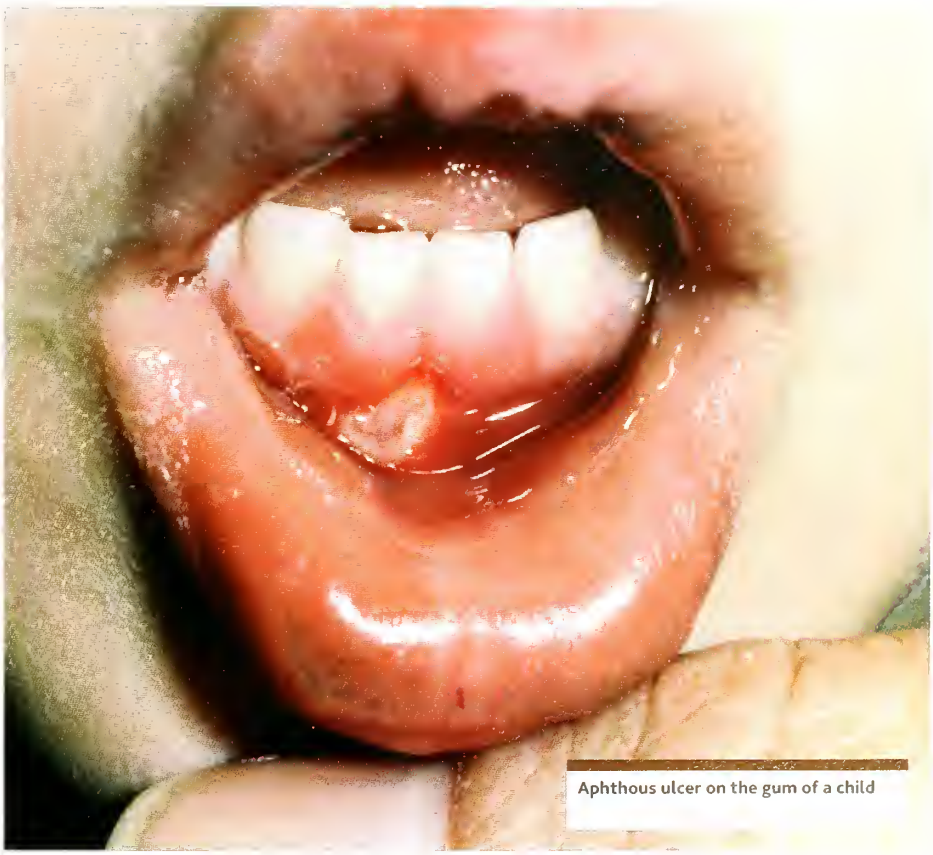
If symptoms only affect the oral cavity then pre-cancerous and cancerous conditions must be eliminated. Leukoplakia is a precancerous lesion that looks like oral thrush, as it presents as a white patch anywhere in the oral cavity but especially on the tongue and cheek.

The cardinal differences between thrush and leukoplakia are that leukoplakia causes no pain and cannot be wiped away. Although only a small percentage of leukoplakia lesions develop into cancer they must be referred.

Squamous cell carcinoma causes around 800 deaths in the UK each year. Like leukoplakia, it is more common in smokers and 90 per cent of cases are seen in people over 40 years old. The majority of cancers are on the side of the tongue, mouth and lower lip.

Initial presentation ranges from painless spots, lumps or ulcers in the mouth or lip area that fail to resolve. The painless nature of early symptoms leads people to seek help only when other symptoms become apparent. Urgent referral is needed as survival rates increase dramatically if the disease is diagnosed in its early stages.

Other oral lesions that cannot be managed OTC include major aphthous ulcers, herpetiform ulcers and herpes simplex infection. Major ulcers are large (more than



Aphthous ulcer on the gum of a child

Picture: Dr P Marazzi/Science Photo Library

The College of Pharmacy Practice

This course (module 1383), in association with multiple choice questions being published in C+D November 4, provides one hour's continuing education

CPD

This article [illegible] the following [illegible] competencies: [illegible] G1d, [illegible] www.tinyurl.com/[illegible]

Panel 1: How to perform an oral examination

The oral cavity can easily be examined in the pharmacy provided the mouth can be viewed with a good light source, preferably a pen torch. The basic steps are:

1. Wash your hands.
2. Examine the lesions/problem area of the oral cavity the person has presented with.
3. Once checked, inspect the rest of the oral cavity for any other ulcerated/sore areas of the mouth.
4. To view floor of the mouth and underside of the tongue, ask the patient to curl their tongue towards the roof of the mouth.
5. The buccal mucosa is best observed when the patient half opens his or her mouth.

Panel 2: Counselling tips

Application of triamcinolone

- Apply after food, as food is likely to rub the paste off.

Application of miconazole gel

- Patients should be advised to hold the gel in the mouth for as long as possible to increase contact time between the medicine and the infection.
- Gel is orange-flavoured to make retention in the mouth more acceptable.

Miconazole and chlorhexidine treatment

- Treatment should be continued for up to two days after the symptoms have cleared.

Key points

- Questioning should be supplemented by an oral examination.
- Minor ulcers and oral thrush are associated with some degree of pain.
- Systemic symptoms or skin rash associated with oral lesions should be referred for further investigation.
- Any painless lesion must be referred to exclude sinister pathology.

Table 1: Key and distinguishing features of oral ulceration and thrush

	Oral ulcers (minor aphthous ulcers)	Oral thrush
Prevalence and epidemiology	• Affects all ages. • Commonest in people aged between 20 and 40. • Lifetime prevalence affects one in five people.	• The very young (approximately 5 per cent of neonates) and the very old.
Predisposing factors	• The cause is unknown despite claims that it is stress-related or due to nutritional deficiency.	• Associated with underlying pathology such as diabetes and dry mouth and with patients who are immunocompromised. • An identifiable risk factor such as recent antibiotic therapy, inhaled corticosteroids or ill-fitting dentures.
Prognosis	• Usually takes seven to 14 days to resolve.	• In neonates spontaneous resolution usually occurs but may take a few weeks. • In adults resolution occurs in five to 10 days providing no underlying pathology or risk factors are present.
Presenting symptoms	• Pain is the key symptom. • Oral inspection will reveal rounded, small (less than 1cm in diameter) grey-white ulcers with a raised red rim.	• Creamy-white soft elevated patches that can be wiped off revealing underlying erythematous mucosa. • Pain, soreness, altered taste and a burning tongue can be present.

Table 2: Probable reasons for oral lesions

Probability	Cause	Management
Most likely	• Minor ulcers	• OTC treatment
Likely	• Oral thrush* and trauma (eg tongue biting)	
Unlikely	• Major or herpetiform ulcers, herpes simplex	• Refer to doctor
Very unlikely	• Lichen planus, leukoplakia, squamous cell carcinoma, erythema multiforme, Behcet's syndrome	

*Underlying medical disorders such as diabetes, xerostomia (dry mouth) and immunosuppression must be eliminated

Table 5: Prescribing information for OTC products

Condition	Treatment	Dosing	Likely side effects	Significant interactions	Care needed
Mouth ulcers	Choline salicylate	>10 yrs. Apply every three to four hours.	None	None	None
Oral thrush	Triamcinolone acetonide 0.1 per cent in Orabase	>12 yrs. Apply two to four times daily.	None	None	None, but makers state there may be very small risk to human foetus in pregnancy.
	Hydrocortisone sodium succinate pellets	>12 yrs. 1 pellet four times daily.			
	Chlorhexidine gluconate mouthwash	> 12 yrs. 10 ml twice daily.	None	None	None
	Miconazole	<2 yrs. 2.5 ml twice daily. 2-6 yrs. 2.5 ml four times daily. >6 yrs. 5 ml four times daily. Adults. 5-10ml four times daily	Nausea and vomiting	Warfarin	None

1cm), numerous and can coalesce to form one large ulcer. Scarring is possible and systemic corticosteroids may be needed.

Herpetiform ulceration is a rare variant of minor ulcers. Ulcers are very small, occur in large crops and usually occur at the back of the mouth.

Herpes simplex infection can result in oral ulceration in children and resembles herpetiform ulcers. Children may also have fever and pharyngitis. Table 4 lists the signs and symptoms that should trigger GP referral.

OTC treatment for ulcers

Treatment choices for ulcers should be guided by the amount of pain experienced and the frequency of ulceration. Patients should avoid acidic food and drinks to minimise pain, as an adjunct to OTC treatment.

Trial data for topical corticosteroids is drawn from small trials and products that are not commercially available OTC. In a recent review Scully concluded that they might speed the healing of ulcers and reduce the pain,[1] although trial data for commercially available products is less convincing. Trials involving triamcinolone acetonide 0.1 per cent in Orabase failed to show increased resolution rates[2,3] and one trial involving hydrocortisone sodium succinate pellets reported relief of pain and accelerated healing rates of ulcers but significance was not reported.[4]

Specific trial data for products containing anaesthetics, analgesics, anti-inflammatories (eg benzydamine) and protectants in treating ulcers is lacking, yet clinical experience suggests they can help relieve pain. A number of random controlled trials investigated antibacterial mouthwashes containing chlorhexidine gluconate and some studies have found that they reduced the pain and severity.

Table 4. Referral signs and symptoms

- Painless lesions.
- Duration longer than three weeks
  Precancerous/cancerous pathology may be present
- Painful lesions greater than 1cm.
  Possible major ulcers, erythema multiforme, Behcet's syndrome
- Crops of numerous ulcers.
  Possible herpetiform and major ulcers, herpes simplex infection
- Skin involvement.
  Possible lichen planus, erythema multiforme, Behcet's syndrome

OTC treatment for thrush

Only miconazole oral gel is available OTC to treat oral thrush. It has proven efficacy and appears to have clinical cure rates of 80 to 90 per cent. In comparative trials, Daktarin appears to have superior cure rates than the POM nystatin gel.[5,6] Prescribing information for the products reviewed is shown in Table 5 and tips on counselling in Panel 2.

See www.dotpharmacy.com for references.
Websites: The British Dental Health Foundation – www.dentalhealth.org.uk

Dr Paul Rutter is principal lecturer, School of Pharmacy, University of Wolverhampton, and former senior lecturer at the School of Pharmacy, University of Portsmouth. He is the author of 'Community pharmacy – symptoms, diagnosis and treatment', published by Elsevier.

Continuing professional development CPD

Reflect

Are you sure of the differences in appearance between oral thrush and mouth ulcers? What oral signs and symptoms should you refer to a GP?

Plan

If you read this article you should be aware of the signs and symptoms of oral thrush and mouth ulcers, their differential diagnosis and the lesions that should be referred to a GP. The article also covers OTC treatments.

Act

- Have you ever carried out oral examinations for any mouth condition? If not, why? Do you have a suitable illumination source?
- Find an authoritative website with illustrations of the less common conditions listed in Table 2, so that you are aware of what they might look like.
- Do you always give patients using inhaled steroids advice on preventing oral thrush? If not, should you?
- Trial data for mouth ulcer products containing anaesthetics, anti-inflammatories, protectants, corticosteroids and chlorhexidine is lacking or unconvincing. Carry out a survey by recording in your practice workbook the next (say) 50 regular patients to whom you supply products for mouth ulcers and ask them to report the results. How valuable are they for symptom relief and facilitating a cure?
- Record in your practice workbook all cases of antibiotic/corticosteroid related oral thrush. Reflect on this with reference to the frequency these products are prescribed. Do these results encourage/discourage you to warn all patients of the potential side effects of their prescribed medicines in these classes?

Evaluate

After reading the article and doing as many of the Actions as you have time for, are you better equipped to give advice on mouth ulcers and oral thrush? If not, what are you going to do about it? Have you amended the advice you provide when dispensing an oral antibiotic or inhaler corticosteroid?

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the November 4 issue, which will cover this week's CPP-accredited module, together with those in the October 7 and 28 issues.

These will cover:
Foot conditions (1382)
Oral lesions (1383)
Shingles (1384)
A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269.

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Smoking COPD risk may be seriously underestimated

At least one in four hardened smokers will develop chronic obstructive pulmonary disease, a large 25-year study published in Thorax has suggested.

The prevalence of COPD among smokers is usually said to be 10 to 15 per cent – half of the new estimates – but these figures have been based on studies of shorter duration, say the Danish researchers who carried out the new study.

The Danish group based its findings on a cohort of 8,000 men and women who were monitored for 25 years as part of the Copenhagen City Heart Study.

At the start of the study their lungs were normal. However, after 25 years the lungs of only six out of 10 male smokers and seven out of 10 female smokers were continuing to work well.

The risk of COPD plummeted among those who gave up smoking soon after the study began; none of the ex-smokers developed severe COPD.

For more information:
http://tinyurl.com/ygsp4m

Table 3: Questions to ask the patient (see Clinical Update, p23)

Question	Reason for asking
Number of lesions?	• Minor ulcers occur singly or in small crops. • A single lesion is suggestive of thrush, major ulcers or leukoplakia. • Numerous ulcers are suggestive of herpetiform ulcers.
Location of lesions?	• Lesions on the side of the cheeks and tongue are more likely to be due to thrush than minor ulcers. • Lesions toward the back of the mouth are more suggestive of major or herpetiform ulcers. Note though that thrush precipitated by inhaled steroids can produce lesions that appear on the pharynx.
Shape of lesions?	• Irregular-shaped lesions tend to be caused by trauma. • If lesions are large or very small then minor ulcers are unlikely to be the cause. • Lesions that appear as patches are suggestive of thrush or leukoplakia. • Minor aphthous ulcers tend to be superficial and shallow, whereas major ulcers tend to be deeper and more crater-like.
Pain free lesions?	• Painless lesions must be referred as they may indicate sinister pathology.
History of symptoms?	• Ulcers from trauma will be linked to an event that triggered the lesion, eg toothbrushing or biting inner surface of the mouth. • Aphthous ulcers are typically associated with recurrent bouts (recurrent aphthous ulcers). It must be remembered that, at some point, patients will present for the first time with aphthous ulcers.

A Practical Approach... last week's answers

1. No. For people with type 1 diabetes, inhaled insulin can be used to replace short-acting but not long-acting subcutaneous insulin.
2. No. Russell would have to wait until he has not smoked for at least six months, as smoking greatly increases the rate and extent of absorption of inhaled human insulin, and could increase the risk of hypoglycaemia. If he resumed smoking, inhaled insulin therapy would have to stop immediately.
3. Russell's recommended starting dose would be 1x3mg blister three times daily, inhaled not more than 10 minutes before a meal. The SPC for the drug (Exubera) provides a dosage table (11st 2lb = 71kg).
4. Inhaled insulin should be stored in ambient (not more than 30°C), dry conditions.

A Practical Approach...

David Spencer, pharmacist proprietor at the Update Pharmacy, is interviewing a young woman for the post of relief pharmacist, and is considering offering her the job.

"That's everything I wanted to ask you," he says. "Have you got any questions for me?"

"No, but there is something I need to tell you. I'm Roman Catholic and object to artificial methods of contraception and abortion. I would not be willing to supply emergency hormonal contraception or hormonal contraceptives and I would not allow condoms to be sold while I was on duty."

"So what would you do if you had a request for EHC or a script for a contraceptive?" asks David.

"I would politely tell the customer that I could not supply them because of my religious beliefs, and direct her to the nearest pharmacy where I knew she could get them," she replies.

"On that basis, I'm not sure I would be able to employ you."

"I think it would be religious discrimination if you didn't."

"I need to take advice on that. I'll let you know," says David.

Questions

1. Can a pharmacist ethically refuse to supply EHC or other forms of contraception?
2. Would David be guilty of religious discrimination if he declined to offer the pharmacist the job on these grounds?

CPD

This article can help in the following CPD competencies: G1h, G4m, C6d. See www.tinyurl.com/194zu

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Clinical news

Nice decision on drugs for Alzheimer's met with anger

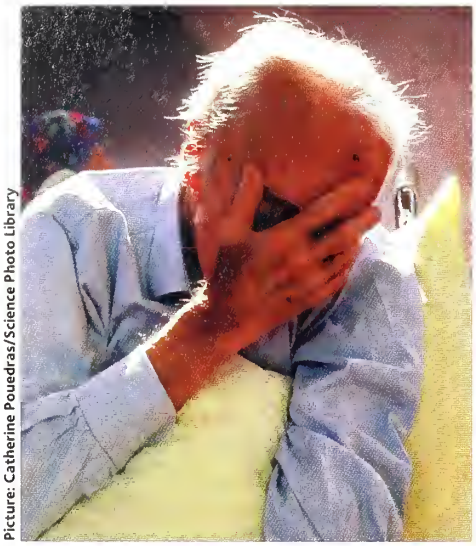
An appeal decision by Nice to recommend Alzheimer's disease treatments only in patients with moderately severe symptoms has met with widespread anger.

The Nice appeals panel upheld an earlier decision that donepezil, rivastigmine and galantamine could not be recommended for patients with milder Alzheimer's disease symptoms. The new ruling added that memantine should be used only in the course of clinical trials.

The decision met with renewed opposition from the charities, doctors' groups and pharmaceutical companies who had placed the appeals.

The Royal College of Psychiatrists strongly urged Nice to return to its position following the 2001 appraisal, and argued that Nice's decision to exclude patients with mild symptoms was flawed. It also said that the decision on memantine was not justified, as the outcome measures for the drug were similar to those for the cholinesterase inhibitors.

The Alzheimer's Society claimed that the new ruling took no account of likely increases in the use of alternative drugs, and pointed to a study published last week in the New England Journal of Medicine, which revealed that although antipsychotics can reduce aggression and agitation, the benefits are offset by side effects.



Picture: Catherine Pouedras/Science Photo Library

The Society also claimed the decision not to recommend the treatments ignores benefits to carers and contradicts government policies on early intervention and maintaining patients' independence.

The US Food and Drug Administration has announced approval for donepezil to be used in the treatment of severe Alzheimer's. It is already approved for use in mild and moderate Alzheimer's disease in the USA.

Self-management does not cut pain

Self-management programmes in arthritis may not be effective in either reducing pain or numbers of visits to the doctor, suggests a new study by researchers from the Royal Free Hospital.

This finding contradicts previous evidence that has led the government to promote self-care for chronic disease through primary care.

In the study, 812 patients aged over 50 years with osteoarthritis of the hips and knees were randomised to either a series of self-help sessions and an education booklet, or the booklet alone. Follow-ups took place at four and 12 months.

Although the intervention group were less anxious and more confident of their ability to manage their condition, there were no significant differences between the arms of the study in terms of pain, physical functioning or visits to the GP.

The researchers concluded that optimum management of these patients remained unclear, and that the benefits seen in this trial of self-management did not justify a policy of actively recruiting patients to self-management programmes.

Cochrane less favourable to drugs

Industry-supported meta-analyses comparing drugs should be read with caution, suggests a systematic study by the Nordic Cochrane Centre published in the BMJ.

The study compared the quality and conclusions in Cochrane reviews with those in industry-supported meta-analyses or where no support was declared. It found a total of 24 meta-analyses that matched similar Cochrane reviews.

Compared with Cochrane reviews, the industry-supported reviews were less likely to consider the potential for bias in the results.

Also, although seven industry-supported reviews recommended the experimental drug without reservations, none of the Cochrane reviews did so.

The reviews with no declared support were as cautious as the Cochrane reviews, the researchers added.

Porcine insulin supply to continue

Wockhardt has announced that it will continue to supply porcine insulins, beyond the December 7 date Novo Nordisk has set to cease marketing its own porcine insulin products.

Estimates suggest that 12,000 people currently use porcine insulins.

The products about to be withdrawn are Pork Actrapid, Pork Insulatard and Pork Mixtard. Patients currently on these treatments are advised to see their diabetes healthcare professional for advice about changing their insulin.

Wockhardt suggests that Porcine Neutral, Porcine Insulatard and Porcine 30/70 mixture respectively from its Hypurin range are the nearest equivalents to the products being withdrawn.

The company adds that it will continue with porcine insulins 'for the foreseeable future'.

For more information:
Tel: 01978 661261
www.wockhardt.co.uk

NSAIDs under surveillance again

The European Medicines Agency is to review the evidence on the cardiovascular safety of non-selective NSAIDs following studies suggesting increased thrombotic risk in long-term treatment with ketoprofen, ketorolac and piroxicam.

The new review follows an earlier similar report published as recently as October last year.

The EMEA has advised people taking non-selective NSAIDs to continue with their treatment, and emphasised the established message that NSAIDs should be used at the lowest possible dose for the shortest possible duration.

In brief

New papilloma virus vaccine

Sanofi-Pasteur has launched a vaccine against human papilloma virus – the virus responsible for cervical carcinoma, high-grade cervical dysplasia and external genital warts. The vaccine is designed to immunise against papilloma virus types 6, 11, 16 and 18. Named Gardasil, it is available in a pre-filled syringe priced at £80.50.

For further information on Gardasil go to http://tinyurl.com/y27qza

New TENA Lady Mini Magic from the UK's number one bladder weakness brand.

New **TENA *Lady* Mini Magic™** is big news for millions of women who experience bladder weakness and that's big news for you too.

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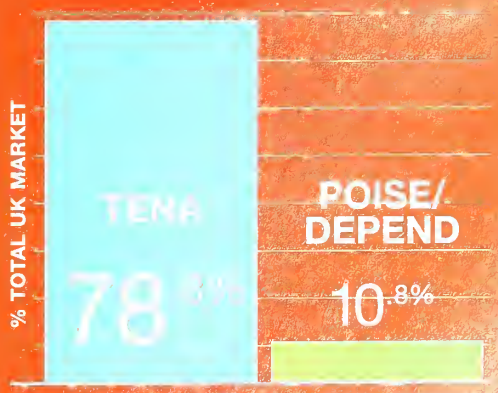
MINI	277-8215	10 X 20 (200)
MINI PLUS	280-6859	10 X 16 (160)
NORMAL	259-4448	6 X 12 (72)
EXTRA	259-4455	6 X 10 (60)
EXTRA PLUS	304-1639	6 X 8 (48)

TENA. The UK's No.1

UK sales of bladder weakness products 2006



(Source: IRI 52 week ending 12.08.06 value)

www.tena.co.uk

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For your **FREE** TENA sample bag containing all 70 TENA products, please contact the TENA Pharmacy Helpline on **0870 333 0874** quoting: C&DP21.0[illegible]

Please note that the increasing number of requests for samples means that it is now necessary to limit them to two per pharmacy each year.

Natural approach to body washes

Three 'green' body washes have been launched by Weleda.

Wild Rose Creamy Body Wash is formulated to nourish the skin with organic rose oil and organic sesame oil to reduce water loss. The product leaves the skin soft and smooth, says the company, and can be used in the bath or shower. Sea Buckthorn provides a revitalising experience while the Citrus variant is described as invigorating.

The products are made with natural cleansing agents, which are mild and biodegradable, causing no harm to aquatic life, adds Weleda.

Packaging is recyclable and eco-friendly. It is endorsed by the BDIH scheme as a certified natural cosmetic and is suitable for vegetarians and vegans.

Trade parcels of six or 12 of each body wash are available together with free point of sale materials.

Price: £6.95/200ml

Product info:
Weleda Retail
Tel: 0845 200 2836

Hallowe'en launch from Witch

The Witch skincare range has been extended with the launch of two facial products.

Radiance Serum contains hydrating and skin brightening ingredients to leave the skin soft and smooth with a natural glow, says the company.

The second product, Hydrating Gel, is a moisturising gel incorporating SPF10 to hydrate and protect against UV rays. Both products contain extract of witch hazel.

Prices: serum £6.49/50ml; gel £5.79/75ml

Product info:
De Witt
Tel: 01928 579029

Products in brief

On the pulse

An automatic blood pressure and pulse monitor has been launched by Ciga Healthcare.

The Suresign monitor is an upper arm monitor and features a full cuff to take both blood pressure and pulse measurements. An internal pump inflates and deflates the cuff and the device can store up to 36 readings.

Price and Pip code: £19.99, 324-8622

Ciga Healthcare
Tel: 028 2568 5385
www.cigahealthcare.com

WoodSilk is the new black

Activa Healthcare has launched the WoodSilk Sock compression hosiery, said to offer comfort, style and health benefits.

The sock is made from wood fibres from sustainable sources, knitted to produce 'almost seamless' transitions between toe, heel and welt to reduce friction and improve comfort.

The sock is indistinguishable from ordinary hosiery and expected to appeal to young and old people, says Activa. Garments must be renewed every three months. Two BS compression classes are available: 14-17mmHg (class one) for superficial varicose veins and preventing deep vein thrombosis and, on prescription only, 18-24mmHg (class two) for more advanced, painful varicose veins and swollen ankles. Both come in black, with the class 2 variant also available in brown.

Price: £10.21/pair

Product info:
Activa Healthcare
Tel: 08450 606 707
www.activahealthcare.co.uk

Products for winter season

Don't miss the C+D Winter Remedies supplement included with this issue. GSK is launching Beechams All-in-One Liquid Pocket Packs for relief on the move from headache, blocked nose, sore throat and chesty cough. New variants from Lemsip include the Soother hot drink, Max Breathe Easy and Max Day and Night. Strepsils now offers a dual action variant and Thornton and Ross has launched a trial size of its mentholated cough mixture.

See pages 11 to 13 of the supplement for further details.

Fast food supplement

For busy people looking for a quick VMS solution, Bio-Synergy Multivitamin Mouth Strips are now available.

Each orange flavoured strip melts on the tongue to deliver vitamins C (15mg), E (0.5mg), K (0.044mg) and B6 (1mg). Two to four should be taken daily, at various times, for optimum benefits, says Bio-Synergy.

The strips are packaged in a resealable pack which can be kept easily in a coat pocket or handbag. The product is also expected to appeal to those who find it difficult to swallow tablets. For children, the company has launched Bart Simpson branded vitamin C strips. Two should be taken daily.

Price: £1.99/24

Product info:
Bio-Synergy
Tel: 020 7569 2528
www.bio-synergy.co.uk

Changing the way we supply our medicines

The need for change

We are changing the Pfizer UK supply and distribution arrangements to allow us to take full responsibility for our medicines from the point at which they leave our manufacturing centres until they are sold to our customers who dispense them.

As the major supplier of
aware of, and increasingly
the supply chain and the
are confident that as a re

- be better able to man
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complete confidence.

How will it work?

- Pfizer prescription medicines will be distributed by UniChem Limited
- Pfizer and UniChem will jointly ensure full coverage for all new and existing UK customers, and ensure current service patterns are maintained

THE NEW DISTRIBUTION ARRANGEMENT
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Please ask my local Pfizer pharmacy representative/dispensing account specialist to visit to discuss this new arrangement: ☐

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Tuesday	☐	☐	Thursday	☐	☐			

To find out more, please log on to www.pfizerdtp.co.uk

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Working w

Pfizer believes that pharmacists are increasingly important customers. The new distribution arrangements will enable us to get closer to pharmacists and over time develop a beneficial partnership.

We will continue to maintain our substantial financial investment in distribution and continue to offer cash discounts because this is what pharmacists have told us they want.

Over time, our intention is to develop a wider range of other service-based offerings for pharmacists, based on analysis of customer needs and the new pharmacy contract.

Freeze away the pain of injuries with Mentholatum patch

The WellPatch Deep Freeze Cold Patch has been launched by the Mentholatum Company. Said to be the first cold patch for injuries in the UK, the patch works on the same principle as ice, says the company.

The product has a hydrogel coating containing water, menthol and aloe vera that evaporates on use to produce a cooling action to numb pain, stabilise the injury and promote healing.

The flexible patch is applied directly to the skin and does not need to be refrigerated. Its effects last for up to three hours and it can be used alongside oral painkillers, says Mentholatum.

In-store sampling, promotions, cross-brand offers and a £750,000 consumer package are supporting the launch.

Product info:
PowerMed Healthcare/ Prima Brands (Northern Ireland)
Tel: 0845 222 0555/02890 814700

Price: £4.99/four
Pip code: 322-9358

Health Perception doubles up

Two maximum strength joint care products have been added to Health Perception's GlucOsamax range.

GlucOsamax Extra includes white tablets containing glucosamine and chondroitin and pink tablets containing MSM, rosehip and omega-3.

GluChonmax includes 2000mg glucosamine 2KCl providing 1,500mg glucosamine in one tablet and 1,200mg marine source chondroitin plus 300mg omega-3 in the second.

Product info:
Health Perception
Tel: 01252 861454
www.health-perception.co.uk

Price: Extra £19.99/30+30; GluChonmax £21.99/30+30

Platinum debut from Solgar

Platinum Edition Nutri-Nano CoQ10 is newly available from Solgar Vitamin and Herb.

The nutritional supplement uses nanotechnology to offer improved bioavailability. The method converts fat soluble nutrients to amphiphilic ones, aiding absorption in the small intestine, says the company. It is the first product to be launched in the Platinum Edition range.

Product info:
Solgar Vitamin and Herb
Tel: 01442 890355
www.solgar-vitamins.co.uk

Price: £39.79/50

Products in brief

Perfect mask

Infallible Concealer has been launched by L'Oréal Paris. Said to hide dark circles and cover up imperfections all day, the stick comes in five shades.
Price: £5.49
L'Oréal Paris
Tel: 0161 655 1400.

Loo role for baby MD

Triple Velvet toilet tissue is being advertised on television in an autumn campaign. Two 20-second and one 10-second ad featuring the baby managing director concept are being screened nationwide.
SCA Hygiene
Tel: 01582 677400.

Miss Sporty goes surfing

The Miss Sporty cosmetics brand has launched a website. Carrying information on products, make-up tips, competitions, links and games, visitors can register to create a personalised home page.
Coty Inc
Tel: 01233 656366.
www.miss-sporty.co.uk

Products advertised on TV next week

Sponsored by Calpol

Cura-Heat Arthritis Pain Knee: C4, five
Cura-Heat Back & Shoulder Pain: C4, five
Cura-Heat Arthritis Pain Wrist: C4, five
DulcoEase: GMTV
TENA Lady Mini Magic & TENA pants: All areas
Seven Seas Cod Liver Oil: All areas
PharmaSite for next week: Anadin Ultra – Windows, **Anadin Ultra** – In-store, **Anadin Ultra** – Dispensary
Pharmacy channel: Anadin Ultra Double Strength, Eucerin, Dulcolax, Canesten-Hydrocortisone, DTECTA Probiotics

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

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Colpol Infant and Sugar-free Infant Suspension Product Information: **Presentation:** Suspension containing 120mg Paracetamol per 5 ml **Uses:** Treatment of mild to moderate pain and as an antipyretic **Legal Category:** 200ml bottle, P. 100ml bottle; GSL. Sachets, GSL. **Further information is available from:** Pfizer Consumer Healthcare, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS
www.calpol.co.uk

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Calprofen Product Information:
Presentation: Suspension containing 100mg Ibuprofen per 5 ml. **Uses:** Treatment of mild to moderate pain and as an antipyretic. **Legal Category:** 200ml bottle: P; 100ml bottle: GSL. **Further information is available from:** Pfizer Consumer Healthcare, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. **www.colpol.co.uk**

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Group Art Editor
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Editorial Production Assistant
Bethany Straker
Editorial Secretary
Jan Powis (tel): 01732 377487
(fax): 01732 367065
chemdrug@cmpmedica.com

Price List
Colin Simpson (Controller)
01732 377407
Darren Larkin (Data Manager)
Price List (fax): 01732 377559
Sandra Drawbridge
(Data input clerk)
C+D Data
David Watkinson (Director)
01732 377802
Devi Patel (Development Manager)
01732 377451
Maria Locke (Data Development clerk)
Commercial Director
Mary McGregor
Sales Director
Roy Jacques 07818 454831
Group Advertisement Manager
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Sales Managers
Daniel Spruytenburg 020 7921 8126
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Amy Miller 020 7921 8124
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Pauline Sanderson 01732 377269
Production
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Marketing Manager
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Elaine Steele 01732 377621
Publishing Director
Phil Callow

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News Editor
01732 377688

Business Editor
01732 377315

Clinical and CPD Editor
01732 377463

Marketing Editor
01732 377600

Features Editor
01732 377435

Email
firstinitialsurname@cmpmedica.com

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Weighing analgesic risks and benefits

Hooman Ghalamkari
Community pharmacy owner and member of Medicines Partnership Task Force

Customers often base their choice of analgesic on previous use, advice from a friend, or advertising. However, pharmacists and their staff must ensure that the product sold is suitable for the individual.

Non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen provide effective relief of pain and fever, and may be slightly more effective than paracetamol for some people. However, NSAIDs are known to interact with certain drugs, and have been linked with increased risk of adverse events, such as gastrointestinal problems, cardiovascular or renal problems, and hypersensitivity reactions in some asthmatics. Although NSAIDs have anti-inflammatory properties, these can take up to 3 weeks to appear, and are only seen at prescription doses (above 1600 mg/day for ibuprofen).[1]

Paracetamol is an effective analgesic and should be used first line for muscle and joint pain (e.g. osteoarthritis or mild arthritis), based on its few significant adverse events or clinically significant drug interactions. If paracetamol (at 4000 mg/day) gives insufficient relief, a combination analgesic is recommended.[2] Topical NSAIDs are a well-tolerated alternative to oral NSAIDs, and can be used either alone or alongside paracetamol.

There are several ways to reduce the risk of drug-related adverse events:

- Ensure patients are informed about the possible side effects.
- Elderly people are at greater risk of adverse events, so analgesic use must be carefully balanced against the risks.
- If recommending oral NSAIDs, use the minimum effective dose.

When used appropriately, non-pharmacological treatments carry little risk, and can be effective as part of a muscle or joint pain management programme. Common examples include exercise, weight reduction, cold or heat therapy, dietary supplements (e.g. cod liver oil), and physical supports or aids.

Pharmacy personnel have a duty of care to ensure that requests and recommendations are effective and appropriate. The product of choice is therefore one that is effective and carries the least risk for the individual being treated.

References: 1. British Medical Association et al. British National Formulary 51. 2006. Available at www.bnf.org. 2. Zhang W et al. Ann Rheum Dis 2005;64:669-681.

This 4-week series was sponsored by Panadol®
For further guidance on the management of muscle and joint pain please refer to the ALGORITHM CARD enclosed in this issue of Chemist + Druggist.

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Paracetamol

News and views from the Pharmacy Show

Speakers from this year's biggest community pharmacy event at Birmingham's NEC give C+D their views on the state of the profession

Five steps to pharmacy prosperity

There are five steps to prosperity in pharmacy, believes Charlotte Wilson, business development consultant at Pharmacy Partners.

Firstly, pharmacists need to free up some time. "The pharmacist is your most important asset, they are the ones that think, plan and implement the business strategy," she said. But the new pharmacy contract means there is less time than ever before, she says, which points to the second step to prosperity – the need for business efficiency. This can be achieved by assessing work processes and using IT and accredited checking technicians to deliver management or patient-facing roles, she said.

Thirdly, pharmacists need to look after patients by managing their service expectations and creating a professional impression through the use of uniforms and clean premises.

Pharmacists also need to look after their staff, by holding regular meetings and involving them in management issues, "to help them understand their contribution to your bottom line".

Pharmacists need to manage their businesses, through planning, budgeting and performance measuring. Finally, she thinks pharmacists need to ask themselves: "Are you a product shifter or a service provider? You can't rely on the government to invest in your business – if anything, they are going to increase the amount they are clawing back."

Trust me, I'm a pharmacist

Pharmacists and pharmacy organisations need to regain the public's trust, an industry leader has said.

Speaking at the Pharmacy Show on October 15, Dave Fisher of the Association of the British Pharmaceutical Industry said that the pharmacy industry is not exempt from public suspicion in a post-Shipman era.

"Despite relatively high confidence levels in pharmacists, we still have trust issues with at least 14 per cent [of the public] having an unfavourable opinion of us," Mr Fisher said.

He believes that the way to regain the public trust is to focus on the patients themselves. "Putting patients first is not new," he admitted, "but we do often forget our raison d'être is just to help them."

The right medicine, right patient, right time

The ABPI has a new manifesto designed to gain patient trust. Dave Fisher, commercial director, said: "It's not simply moral but practical and financial – the right medicine, for the right patient, at the right time is a simple idea and one which will determine what activities we'll support over the next few years."

Pharmacists need to look after patients by managing their service expectations and creating a professional impression

Stop whingeing, says president

Pharmacists must deliver solutions to current healthcare difficulties rather than add problems, the president of the RPSGB, Hemant Patel, has warned. "If we [pharmacists] want to be liked, if we want to do business with people, we have to go to people with solutions," he said.

"I think whingeing about £300 million lost in discounting ... does not help at all, it doesn't progress us any further. But perhaps thinking about alternative solutions that will benefit the interested parties is a way forward and we should be providers of solutions rather than mere whingers," added Mr Patel.

Pharmacists should be developing solutions in these six key areas, said Mr Patel:

- Musculoskeletal disease.
- Respiratory disease.
- Heart disease.
- Cancer.
- Diabetes.
- Kidney disease.

The profession must embrace new ways of working to meet these targets including using other members of staff like technicians, he said.

The customer is alv

What your shop front says about you

Smartening up your shop front could help tidy up trade at your pharmacy, a pharmacy entrepreneur has said.

The right window display and fascia is crucial to attracting extra customers, stressed Kirit Patel, chief executive officer at Day Lewis Pharmacy group. "Get the window and shop floor right and the footfall follows," Mr Patel told delegates at this week's Pharmacy Show in Birmingham.

He said: "I guarantee that 50 per cent of you have not changed your fascia in the past few years. If a hotel did not buy new beds every few years then customers would not come back. If you drop the standards then customers will walk."

Mr Patel's other business-boosting tips included:

- Window displays can act as a catalyst for clearing old stock.
- Don't stock too many non-healthcare lines as it gives patients the wrong impression.

How to deliver the self-care revolution

There is a self-care revolution, and customers are coming to your pharmacy. This is the message category management experts want to get across.

Speaking at the Pharmacy Show, David Wendland, vice-president of the Hamacher Resource Group, said: "Pharmacists can deliver the services, but providing them demands a time and financial commitment." However, successful category management is four steps away, he says:

- Correct department sizing and adjacency mapping: installing your MUR room is the ideal time to rethink your categories.
- Understand brands' profit contribution: by using a reliable and impartial road map.
- Inventory management: products will not sell as well when there is only one unit left on shelf, as when there are two or three.

Customer service excellence: a pharmacist cannot be all things to all people, so delegate tasks, and implement planograms as quickly as possible.

s right

eeping your customers smiling is the key to unning a successful pharmacy business, a top ustomer service expert told pharmacists.

Paul Cooper, communications director for the nstitute of Customer Service, said that harmacists need to wake up to the potential of ood customer service.

"Of course they'll always have to come in for heir medication, but why do they come to you? nd do they buy their shampoo with you as well? Making that happen is down to good customer ervice," he said.

He believes there are four golden rules on the oad to satisfied customers: 1) Go the extra mile;) Make it personal; 3) Deliver your promises;) Deal with complaints and queries brilliantly.

He said that pharmacists must adopt the hantra: "The customer may not always be right – ut they're always the customer."

Go local

Independent pharmacy must cash in on a craze for local goods among consumers according to Numark's managing director.

Contractors could replicate the recent success of regional food producers by emphasising their community appeal, said Simon Colebeck.

"Local shops like butches and farmer's markets are experiencing a huge revival. Many are exploiting their locality and you can benefit in the same way," he told delegates at this week's Pharmacy Show in Birmingham.

Mr Colebeck outlined "golden rules" to help independents rally against the expansion of multiple pharmacy rivals. These include:

- Embrace change. Avoid the fate of the "Luddites" and "flat earth society".
- A smart fascia is key to business, with 85 per cent of customers snubbing outlets with scruffy exteriors, according to a Numark survey.
- Embrace additional services.
- Add a personal touch. It's vital to keep customers coming back with the advent of EPS and nomination.
- Encourage staff to cross-sell products and healthcare services.

Nit Nurse versus Neem

An evergreen tree has been hailed as the new miracle cure for head lice.

Called the Neem Tree, it is known by rural Indians as the "village pharmacy" because it is thought to cure diseases and disorders from ulcers to malaria.

Dr Mark Cole, product development manager at Bioforce Ltd, said recent research carried out by the University of Glasgow had validated its effectiveness in combating the condition.

Dr Cole added that the formula contains four benefits to react against the lice, such as its toxity to insects and its ability to prevent normal lice-egg production. He said: "Azardirachtin is the tree's natural active ingredient and the oil is then pressed and purified to become effective in killing the lice.

"Unlike other synthetic products on the market which have to be left in the hair, the Neem shampoo does not need to be combed through and can be rinsed out immediately after applicat

C+D &
SEVEN SEAS PULSE

TUTORIAL 38

Omega-3 fish oils and cardiovascular disease

OBJECTIVES

- To understand why the benefits of fish oil supplements have been questioned in the consumer press
- To know what the experts' response has been to recent clinical reviews
- To know what the current dietary recommendations are for the consumption of omega-3 fatty acids
- To be able to advise customers effectively on the cardiovascular benefits of fish oil supplements

The cardiovascular benefits of fish oils were questioned earlier this year in a Cochrane review. A subsequent review in the USA re-affirmed that fish derived omega-3 fatty acids do reduce rates of myocardial infarction and sudden cardiac death. The Cochrane review made headlines in the lay press, while the American paper did not. So what is now best advice for customers?

Accredited by
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G1a, G1c, G1q, C2a

The reputation of long-chain omega-3 fatty acids as being beneficial to heart health has fuelled sales of fish oil supplements and led to government recommendations to increase oily fish consumption. Two reviews of the evidence have been published this year. One re-affirmed that fish-derived omega-3 fatty acids do reduce rates of myocardial infarction and sudden cardiac death, but the other found the evidence less clear. So what is now best advice for consumers?

An accumulation of evidence over the past three decades has persuaded scientists and public health advisors to conclude that an increase in omega-3 fatty acid consumption from oily fish or fish oils would benefit the nation's health.

A systematic review of the evidence, published in the American Journal of Clinical Nutrition in August, confirmed fish oils' heart protective reputation, concluding that increased consumption of the omega-3 fatty acids from fish or fish-oil supplements (but not the shorter chain, plant-derived omega-3 alpha-linolenic acid) did in fact reduce the rates of all-cause mortality, cardiac and sudden death, and possibly stroke[1].

This finding was, however, at odds with conclusions drawn by a Cochrane meta-analysis of the risks and benefits of omega-3 fats for mortality, cardiovascular disease and cancer published earlier in the year in the British Medical Journal[2]. It found that 'long chain and shorter chain omega-3 fats do not have a clear effect on total mortality, combined cardiovascular events or cancer'. Despite the authors' comment that the findings should not affect current dietary guidelines and the concerns of nutrition and lipid specialists, the paper was widely publicised in the lay press, but has encountered little acceptance in the scientific community.

What is the evidence base?

Many hundreds of studies were generated following an expedition to Greenland in the 1970s when Danish researchers Bang and Dyerberg and English biochemist Hugh Sinclair made the association between omega-3 fish oils in the Inuit diet and the low incidence of cardiovascular disease[3,4].

The outcome is that scientists have gained improved insight into the role of essential fatty acids in the body and confirmed the importance of the long-chain omega-3 derivatives, EPA and DHA (eicospaentaenoic acid and docosahexaenoic acid) to optimal health and to heart health in particular. The weight of evidence has led the Food Standards Agency (FSA), in common with similar agencies in Europe, America, Australia and elsewhere, to advocate an increase in oily fish consumption[5,6,7].

Omega-3 fatty acids – mechanisms of action

While the cardiovascular benefits of fish oils may be considered established, their precise mechanisms of action are not. Those that are thought to be involved include:

Prevention of thrombosis
Omega-3 fatty acids have antithrombotic actions, attributed to the inhibition of the synthesis of thromboxane A2 from arachidonic acid in platelets[12]. As thromboxane A2 causes platelet aggregation and vasoconstriction, its lack reduces the stickiness of the platelets and improves blood flow. Omega-3 fish oil also enhances prostacyclin production leading to vasodilation and less sticky platelets.

Inhibition of atherosclerosis
Evidence from animal studies shows that fish oil inhibits the development of atherosclerosis by an action independent of effects on blood lipids. This may be associated with reduced synthesis of cytokines and interleukin 1a and stimulation of endothelial production of nitric oxide. A study in vivo shows that dietary fish oil is readily incorporated into atherosclerotic plaques resulting in increased plaque stability, thus reducing risk of thrombus formation [13].

Reduction in susceptibility to ventricular arrhythmia
Fish oils have been shown to help prevent ventricular tachycardia and fibrillation. They appear to protect against arrhythmia by enhancing the electrical stability of heart cells and increasing their resistance to becoming "hyper-excitable". Omega-3 fatty acids also prolong the relative refractory period of the cardiac cycle, thus reducing arrhythmia risk [14, 15, 16].

Inhibition of inflammation
Fish oils stabilise atherosclerotic plaque by reducing the infiltration of inflammatory and immune cells (lymphocytes and macrophages) into the plaque. Heart attacks are now believed to involve the rupture of an atherosclerotic plaque [17].

Reduction of blood pressure
Large doses of fish oils appear to reduce blood pressure in people with hypertension, but not in people whose blood pressure is normal [18].

Reduction in triglycerides
Fish oils have been shown to lower triglyceride levels but effects on cholesterol are mixed. A critical review of 65 trials indicated that short-term supplementation of very high doses (7g) of long-chain omega-3 fatty acids does not influence total cholesterol [19].

What do the experts say?

In the wake of the headlines earlier in the year, the FSA has stated that its recommendations on fish consumption remain unchanged on advice from the Scientific Advisory Committee on Nutrition (SACN), which has reviewed all the available evidence[8].

In addition, the International Society for the Study of Fatty Acids & Lipids (ISSFAL), an authoritative voice on dietary oils and fats in relation to health, articulated the misgivings of lipid specialists the world over in a rebuttal of the Cochrane paper published on line and in the organisation's newsletter [9].

Criticisms of the Cochrane analysis include the omission of relevant studies, the inclusion of irrelevant studies, and contradictory search criteria among others. These are discussed in more detail in the British Medical Journal and in other places[10]. It has been remarked that the findings of the review are out of step with the evidence supporting the heart health benefits of oily fish or fish oil consumption established by other larger trials.

Tom Sanders, Professor of Nutrition, King's College, London, comments: "It is disappointing that when the vast majority of the evidence points to the positive benefits of omega-3 fish oils for heart health, one review paper can cause so much concern amongst consumers."

Professor Clemens von Schacky, University of Munich and a member of ISSFAL, advises that: "The guidelines of the world's largest cardiac societies should be applied. These guidelines state that EPA and DHA prevent cardiovascular disease, prevent sudden cardiac death, and decrease mortality and morbidity of cardiovascular patients. This proven benefit is larger than the benefit of statins, and should not be withheld from persons at risk" [11].

Which omega-3 supplement?

The omega-3 fish oils market splits into three main categories:

- heart health
- joint health/health insurance
- children's health and development.

The heart health protection category is the most mature, with evidence for the association between omega-3 fish oils and cardiovascular disease coming from a wide range of sources.

While nutritionists and dietitians will always recommend the primary food source in preference to supplements, there is considerable resistance in the UK to increasing intake of oily fish such as sardine, herring, salmon and mackerel. Around 87 per cent of the population eat none at all. For people who do not eat oily fish, supplements are readily available. All intervention trials use fish oil capsules in order to provide a standardised dose.

There is little evidence to show that the plant-sourced omega-3 (alpha-linolenic acid) produces similar health effects to the longer chain omega-3 EPA and DHA in fish oils. However, this is the only omega-3 option available to vegetarians and vegans who are advised to take a daily flaxseed supplement while simultaneously decreasing their intake of omega-6 oils and spreads (eg sunflower and safflower).

For heart health protection, SACN has advised the FSA to recommend intakes of 450mg omega-3 fatty acids from oil-rich fish a day for the general population. However, beneficial effects observed in major intervention studies for secondary prevention[20, 21] suggest a target intake of 850mg-1,000mg per day. It is estimated that the average dietary intake of the UK adult population is approximately 200-250mg of long-chain omega-3 fatty acids per day.

Men and women with any one of the heart disease risk factors may best be advised to aim for a daily intake in excess of 450mg whereas those with two or more should consider a total intake approximating to the GISSI study of 850mg a day including dietary intake from food. Higher doses (upwards of 1g per day) are recommended for secondary prevention of heart disease, but the patient's GP should be involved in this decision.

References available on request. Call 01732 377487

Test your knowledge

Test your understanding of this module by answering the following questions. Do this by phoning our Telephone Answering Service on **0800 280** for an immediate response. Dial 1 for the Tutorial Number. The tutorial will listen to the instructions and press keypad numbers to indicate your answers. "1" indicates true, "2" indicates false. Please note that calls are charged at standard national rates.

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Name:

Address:

Pharmacist ❑ Registration No

Technician ❑ Counter assistant ❑

Signature

1. The link between a diet rich in fish oils and cardiovascular disease was first made in a study among Eskimos
❑ True ❑ False

2. The FSA has reconfirmed its recommendation to eat oily fish having reviewed the evidence on omega-3 fatty acids
❑ True ❑ False

3. There are thought to be several mechanisms by which the omega-3 fatty acids in oily fish and fish oil supplements reduce cardiovascular risk
❑ True ❑ False

4. Only about 25 per cent of the UK population ever eat oily fish
❑ True ❑ False

5. Omega-3 fatty acids are believed to prevent thrombosis by the inhibiting synthesis of thromboxane A2 in platelets
❑ True ❑ False

6. The SACN has advised a daily intake of 450mg omega-3 fatty acids from oil rich fish
❑ True ❑ False

7. Mackerel, cod and salmon are all oil rich fish
❑ True ❑ False

8. Clinical trials on omega-3 fatty acids use the primary food source as it is recommended by nutritionists
❑ True ❑ False

9. The omega-3 fatty acids derived from plant sources show similar health effects to those from fish oils
❑ True ❑ False

10. The average UK adult intake of omega-3 fatty acids from diet is 300-350mg
❑ True ❑ False

IPF aims to be independents' HQ

Plans to boost independent sector championed at trade body launch

Independent contractors should see the Independent Pharmacy Federation as their new head office, the organisation said at its official launch at the Pharmacy Show this week.

The IPF aims to become a key resource for the independent sector, providing practical help with changes to category M, and helping independents liaise with PCTs, according to founder member Graham Phillips.

The IPF also plans to be able to offer practical help, for example through mentorship to pharmacists wanting to buy their own businesses, encourage entrepreneurial behaviour and to lobby government on behalf of the independent sector.

"Innovation in pharmacy comes from independents, and the IPF wants to nurture this. The opportunities for pharmacists to grow their businesses are not widely spoken about but they are more available than 21 years ago."

However, Mr Phillips stressed that the IPF would not seek a role as a buying group or competitor to the PDA, NPA, PSNC or RPSGB.

"The IPF wants to work with other pharmacy organisations in a synergistic way. But there are times when independent pharmacy needs to have its own voice."

Manchester-based pharmacist Finn McCaul has been named IPF chairman for the immediate future, according to the organisation, and stated: "We have come to the conclusion there's a huge need for representation among independents."

I have never ventured into pharmacy as a customer before and the show has generated new avenues and I am pleasantly surprised

Craig Allan, owner, The Snack Trap

We are testing the water this year and we have been amazed by the level of response

Mark Wilson and Marc McDonnell UK sales and marketing manager, Micro Medical

We are really pleased with the show. It's a perfect forum [for pharmacists] to solve some of their product problems and to see what else is out there

Chris Whieldon, sales director, Teal Hand Wash Systems

It is fantastic that another pharmacy show is up and running. It's simpler and a lot more focused. It's a great networking opportunity

Mandy Willmore, national sales manager, Powermed Healthcare

Some of the more original stands (left, the Royal National Institute for the Blind stand) gave delegates plenty to talk about

It's a great place to network and part of a long-term strategy for pharmacy. It's more holistic and not just another trade show

Andrew Spurgeon
GSK

I came to network with some new suppliers and it's been a very helpful event

Millen Patel
Milz Ltd

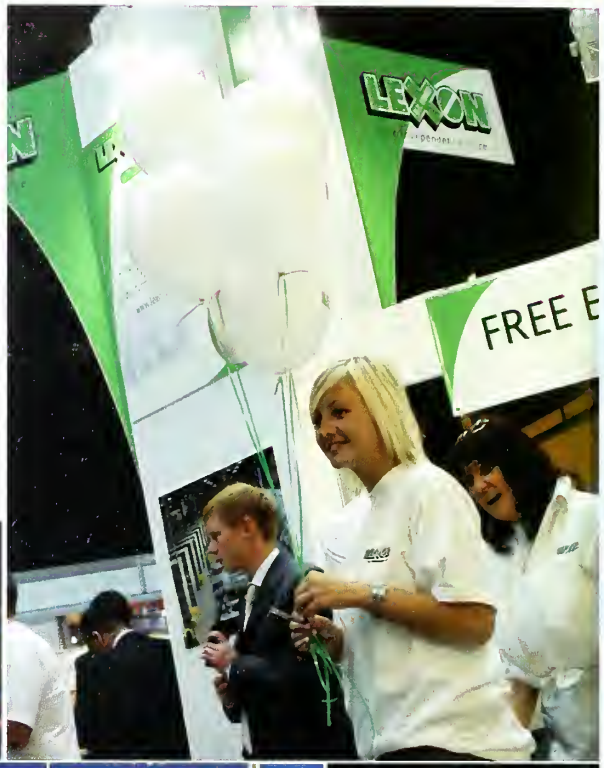
ne seminars are ood because they alance the show ith professional eeds. There's a ood mix of exhibitors nd seminars

rish Savania
SK

I came to look at the digital printing. However, there's been lots of other useful things and I found the seminars very interesting

Pradip Modi
Sheridan Chemist

C+D's stand at the show (left) was eclipsed by flashing lights and people with balloons, as well as the presence of MP Sandra Gidley, RPSGB president Hemant Patel and Numark's Mimi Lau (pictured below)



I will follow up some things that I have seen here but I am disappointed there were not more IT providers or shop fitters

Brian Hunter, pharmacist, Tyne and Wear

I enjoyed the speeches. It's great to hear expert views on the new contract

Gemma Tearle, pharmacist, Tyne and Wear

We have just launched some new retail gels and we are trying to break into the pharmacy market, so this show is a good opportunity

Sam Beaumont, SBC Gels

It's really well organised – very interesting and there are lots of important people here

Kas Ahmed, pharmacist Birmingham

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Appointments

Managers

Chiddingfold Surgery

DISPENSARY MANAGER

Full/Part time

Dispensary Qualifications Essential

Forward thinking dispensing GP Surgery

We are looking for a highly motivated Dispensary Manager with the ability and drive to develop our service further and manage our Dispensary Team.

You should have the ability to translate ideas into reality to enable the Dispensary to achieve its optimum potential.

Salary £20-25K pro rata, depending on experience

Closing Date 27th October 2006
Interviews 3rd November 2006

Call Mrs Lesley Barton, Chiddingfold Practice Business Manager on 01428 683174 for further information or to request an information pack and application form

Dispensers

DISPENSING TECHNICIAN/ASSISTANT
REQUIRED
PINNER, MIDDX
FULL TIME
Experience essential
Salary negotiable according to experience
Contact: H Patel, Carters Chemist
Tel: 020 88660053

DISPENSERS REQUIRED
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Previous experience is preferable - will train

A busy modern pharmacy focussing on care home dispensing is looking for energetic and motivated individuals to join our existing teams of dispensers to provide pharmacy services to care homes in the area.

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COHENS CHEMIST GROUP

Pharmacy chain looking to expand in the North-West & West Yorkshire areas.
Best prices paid, all turnovers/size of groups considered.
please contact Colin Caunce on 07966 524162 or Yakub Patel on 07930 577799.

Adam Myers
For all your healthcare needs

A small group looking to acquire shops in the Midlands, covering Gloucestershire, Herefordshire, Shropshire, Staffordshire, Warwickshire, Worcestershire and surrounding areas.
All turnovers considered, all information treated with strictest confidence and a high premium paid.
For a quick decision please contact Mr Bhandal on 07710 574890
E-mail: csb@adammyers.co.uk

Businesses Wanted

Thinking of Selling Your Pharmacy and Looking for the Best Price?

We are looking to acquire pharmacies throughout England.

Why pay £15,000 - £30,000 in agent's commission? Deal direct and all it will cost you is a phone call.

Day Lewis is a dynamic and rapidly growing chain of 120 pharmacies. We are actively looking to acquire pharmacies of any size, large or small anywhere in England. We are still a family business and retain the core values we had in the early days. We value our staff and invest continually in their training and development. We will pay the best price for your pharmacy and will welcome your staff into the Day Lewis fold. Additionally we will pay you a finders fee of £2000 if you put us in touch with another pharmacy which we buy.

For a completely confidential first stage conversation call **Tony Hough** on 07740 8[illegible]836 or **Kirit Patel jnr** on 07949 122234 or **Alison Bird** (PA to Kirit Patel) on 020 8689 2255 x 221

DAY LEWIS

MANOR PHARMACY

Pharmacy Group looking to expand and acquire shops in the North-West & North/West Yorkshire areas.
All turnovers/ size of group considered.
High Premium Paid. All information will be treated with the strictest confidence.
Please contact Mohamed on 07958 428754 or Talha Patel on 07841 328394

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Pharmacies For Sale

HUTCHINGS PHARMACY SALES

Cambridgeshire	**T/O C:**	**£1,600,000**
Wiltshire	**T/O C:**	**£1,600,000**
Wales	**T/O C:**	**£1,000,000**
Norfolk	**T/O C:**	**£ 660,000**
East Midlands	**T/O C:**	**£ 660,000**
Derbyshire	**T/O C:**	**£ 600,000**
Surrey	**T/O C:**	**£ 520,000**
Hampshire (Village location)	**T/O C:**	**£ 520,000**
South London	**T/O C:**	**£ 300,000**

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*If you are thinking of **SELLING** your Pharmacy, Contact us now for a FREE valuation.*

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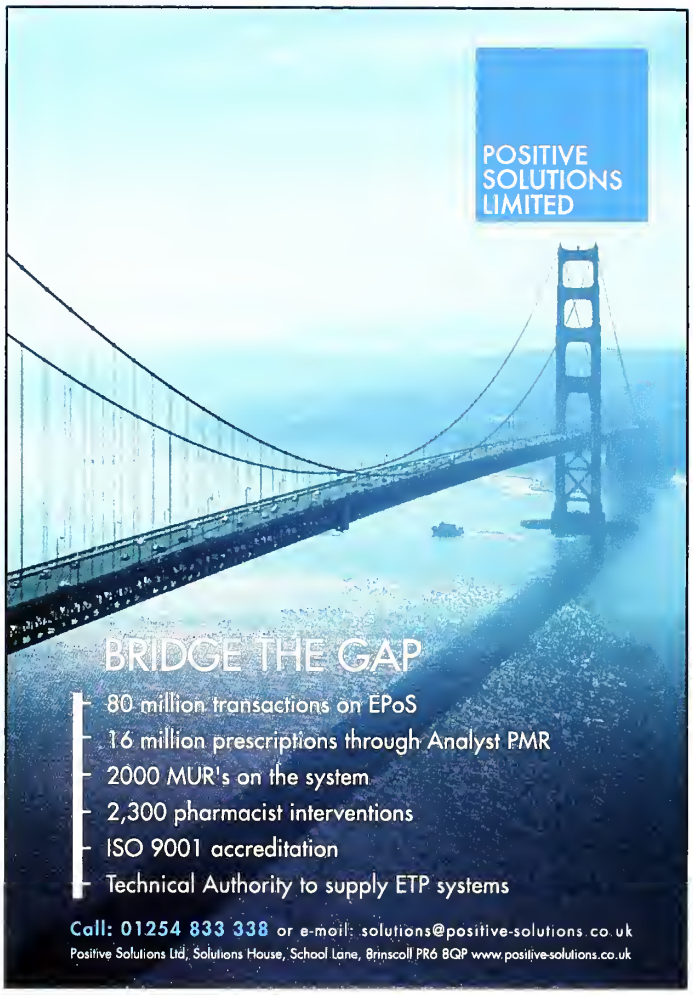

Box Numbers

If you need to advertise in strict confidence you can take advantage of our box number service. A box number will be allocated to your advert and replies will be sent to Chemist + Druggist. We will then forward these to you unopened confidentially.

Call 020 7921 8124 and speak to Amy

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Shopfitting

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Sally scares off the opposition

Is care of scarecrows above and beyond the call of duty?

We all know that the new pharmacy contract is allowing pharmacists to offer enhanced services, but we didn't think that it would stretch to bandaging scarecrows.

Sickly Sally is pictured receiving treatment from pharmacist Ian Gilmore at her local pharmacy, Sylvia Williams, in Cowbridge, Vale of Glamorgan.

Made by Nikki-Lee Stallard, a counter assistant at the pharmacy, Sickly Sally was entered for the Vale of Glamorgan scarecrow competition, which covers Barry, Cowbridge and Llantwit Major.

"There were about 40 scarecrows in total, which were displayed in local houses and shops. I was the winner, but because I had won last year, the judges decided to award the £250 prize to the junior entry. I'm not disappointed because the money will be donated to a local sports club or charity and therefore benefit the community."

Ms Stallard was given £50 in vouchers and said she would probably go on a shopping spree, but not necessarily with her straw companion.

Trek aims high

The wife of a Nucare pharmacist has raised nearly £4,000 for the National Autistic Society. Mira Popat, wife of Hitesh Popat of Popsons Pharmacy in Woodford Halse, Daventry, joined 37 other fundraisers on a five-day trek through the foothills of the Himalayas. The charity said the Trek the Himalayas team is on target to raise £100,000.

Mrs Popat said: "The trek was a memorable experience for all involved and I would like to thank everyone for their generosity and support."

Autistic spectrum disorders are said to affect the lives of more than 500,000 families in the UK. The charity aims to improve awareness and understanding of the condition.

One-stop centre inspired by Cuba

A former mining community in Barnsley has benefited from a £3 million one-stop medical centre based on the philosophy of the Cuban health system.

The Oaks Park primary care centre, which officially opened in Kendray on October 12, gives patients access to pharmacy, chiropody, dietetics, dentists, doctors, midwives, ophthalmology, physiotherapy and psychiatric services.

The concept of a combined health and social care centre was devised by Jim Logan, who is the son-in-law of Arthur Scargill and an ex-manager at the Grimethorpe colliery made famous in the film Brassed Off.

Mr Logan, who funded the development, was inspired by the integrated care centres at the heart of Cuba's health system, which divert patients away from hospitals and contribute to community schemes.

The on-site pharmacy is run by T & I White Ltd Pharmacies, which also has a site in Cemetery Road, Barnsley. Pharmacist Martin Garner said: "It's more than a health centre – it's a community thing."

Appointments

The new chairman of North East London LPC is community pharmacist Alan Castell (left). Ian Mullen has been re-appointed as chairman of Forth Valley NHS Board. He will serve for a further four years.

David Sopp (right) has joined Cegedim Rx as business process manager. He has more than 25 years' experience in finance and IT systems.

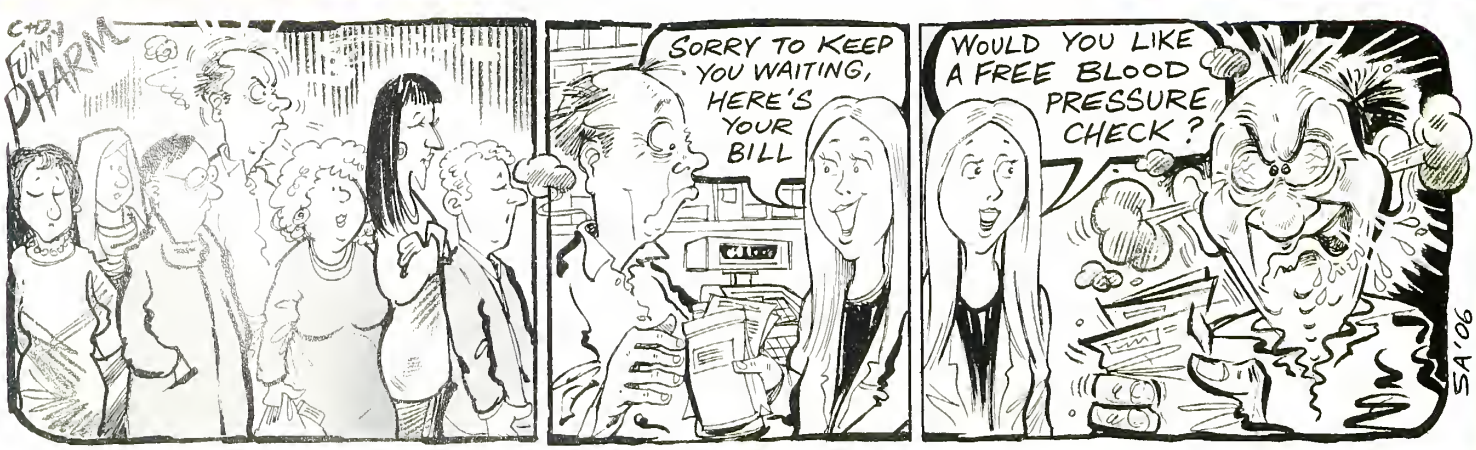
Voice of unreason?

There aren't many health benefits associated with booze, but a new study suggests that drinking can help fill your wallet rather than empty it.

Researchers at the Reason Foundation in the USA report that drinkers earn 10 to 14 per cent more than non-drinkers and men who drink socially, visiting the pub at least once a month, take home an additional 7 per cent in wages. Oddly, women who frequent bars at least once a month do not earn more than their teetotal sisters.

This startling conclusion, made by economists Bethany Peters and Edward Stringham and published in the Journal of Labor Research, appears to contradict the more common wisdom about the effects of alcohol.

One explanation for the fatter wallet, the research suggests, is that the more you drink, the more people you know and the more contacts you have in your Blackberry. Hence the greater the potential to learn where the well-paid jobs are.



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THEY COULD BE MISSING A TRICK

Airborne allergens, such as house dust mites and animal dander, can affect customers all year round. By spraying just once a day, customers can treat all airborne allergy symptoms, from itchy eyes to a groggy head. Flixonase Allergy is more effective than one-a-day antihistamine tablets.[1-8] So put them right and recommend Flixonase Allergy Nasal Spray, because nothing is more effective without prescription.

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Flixonase Allergy Nasal Spray Product Information. Presentation: Aqueous nasal spray suspension containing 50 micrograms of fluticasone propionate per spray. **Uses:** Prevention and treatment of allergic rhinitis. **Dosage and administration:** Intranasal use only. Adults and the elderly: two sprays into each nostril once a day, preferably in the morning. Use twice daily if symptoms persist. Do not use more than 4 sprays a day in each nostril. Prophylaxis of allergic rhinitis requires treatment before contact with allergen. Children under 18 years: Not to be used. **Contraindications:** Hypersensitivity to ingredients. **Precautions:** If symptoms have not improved after 7 days or, if symptoms worsened but are not adequately controlled, consult a doctor. Not be used for more than one month continuously without consulting a doctor. Consult a doctor before use in: concomitant [illegible] products, nasal/sinus infection, recent nasal injury/surgery, nasal ulceration. Risk of adrenal suppression with higher than recommended doses. Significant interactions between fluticasone propionate and potent inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and protease inhibitors, such as ritonavir, may occur. This may result in increased systemic exposure to fluticasone propionate. **Side effects:** Dryness and irritation of the nose and throat, unpleasant taste and smell, headache and epistaxis. Hypersensitivity reactions including skin rash and oedema of the face or tongue. Rarely anaphylaxis/anaphylactic reactions and bronchospesm. Very rarely glaucome, raised intraocular pressure and cataract. Extremely rarely nasal ulceration and nasal septal perforation usually following previous nasal surgery. **Pregnancy and lactation:** Do not use except with medical advice. **Legal category:** P. **Product licence number:** PL 10949/0360. **Product licence holder:** Allen & Hanburys, Stockley Park, Middlesex, UB11 1BT. Further information available on request from Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, Middlesex, TW8 9GS. **Package quantity and RSP:** 60 spray pack £6.99. **Date of preparation:** June 2006. **Flixonase** is a registered trademark of the GlaxoSmithKline group of companies.

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